THOMSON

MEDSTAT

Managed Care Research and Demonstration Task Order
Medicare Choices Demonstration

Verification of Encounter Data
Data Reasonability Analysis - FINAL
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I. OVERVIEW

This report is intended to present a summary of Medstat's evaluation of the data submitted as part of the Encounter Data Validation Project. In the report, we describe the completeness, accuracy, timeliness, and overall quality of data submitted by the Medicare Choices Demonstration plans. Given the nature of these organizations, their information system standards, and the Centers for Medicare and Medicaid Services (CMS) data submission process, these plans faced tremendous hurdles in submitting data. Ultimately, all plans ceased participating in the demonstration and either disbanded or were converted to Medicare+Choice (M+C) plans by December 31, 2000.

A total of 17 plans were originally scheduled for participation in the demonstration; however, only 13 plans ever submitted data. The plans that did submit data experienced significant challenges in the submission of their data to fiscal intermediaries and carriers using established Medicare fee-for-service billing regulations. To help plans overcome submission challenges, Medstat provided extensive technical assistance that included visiting plans in person to address their data availability and submission capabilities, facilitating communication between plans and their fiscal intermediaries and carriers, supplying CMS-approved workarounds to address missing data required for submission, helping plans interpret submission specifications and error reports, and reviewing programming specifications to identify errors as needed. Medstat's technical assistance efforts significantly improved data completeness for many of the plans. However, some challenges plans faced could not be sufficiently addressed by the end of the demonstration. These types of challenges included incomplete data for which workarounds were not available (e.g., diagnoses coded to the highest level of specificity), an inability to bypass certain fee-for-service edits that could not be waived, and insufficient resources at the plans to complete the submission effort before the demonstration cut-off at the end of 2000.

Reasonability

Although most plans successfully submitted at least some data, one of the key questions surrounding the data submitted is the "reasonability" of the data. This can be examined from a number of perspectives, including accuracy of the electronic records relative to the actual medical record, the number of records received compared to expected utilization, and comparisons of aggregate data to external norms and benchmarks.

Examining the completeness of a data set is important for a variety of reasons. Although managed care plans are typically reimbursed on a per member/per month basis, certain reimbursement scenarios (including those applied to some of the Demonstration plans) are affected by the number of encounters submitted and the degree of specificity on those encounters. For plans paid on a risk-adjusted basis, it is important to obtain a full and accurate picture of the plan's enrollees so that plans can be fairly compensated based on the characteristics of their entire population. These plans can directly benefit from submitting complete data.

Additionally, complete and accurate data is important for health services researchers and planners who use data for epidemiological studies and related investigations. Missing or incomplete data can lead to erroneous conclusions about the prevalence, incidence, or correlates of certain conditions.

II. SUMMARY OF QUALITATIVE ANALYSES

Overview of Common Submission Challenges

All of the Choices Demonstration plans that submitted data to CMS for this evaluation encountered various submission challenges that affected the accuracy and/or completeness of their data. These challenges were the result of differences between how health plans record and process encounter data

relative to how fee-for-service providers collect and submit claims data. The most common challenges plans faced included the following:

1. **Difficulty understanding and applying Medicare specifications.** Because most health plans did not have access to Medicare billing experts, they had no previous knowledge regarding the nuances of Medicare fee-for-service billing. In a fee-for-service environment, claims must include specific information beyond basic diagnosis, service, and charge information that enable Medicare fiscal intermediaries and carriers to process the claim accurately. Because the information needed to assign an accurate payment or to ensure that the service provided is covered by Medicare is not necessary for health plans to manage the care they provide to their members or to pay their providers, health plans generally had no experience working with these regulations or incentive to master them. As a result, much of the encounter data that plans submitted for processing lacked information necessary for the fiscal intermediaries and carriers to process the claim accurately. To overcome this barrier, Medstat worked with the plans to interpret and apply specific Medicare billing requirements to their encounter data. In many cases, the information needed (such as a calculation of covered and non-covered days) could be readily derived from the encounter data. In other cases (such as the use of value or occurrence codes), values had to be defaulted, resulting in information that was not accurate or complete in all cases. To help plans understand and apply Medicare submission specifications, Medstat prepared an information guide titled, "The Medicare Encounter Data Submission Guide for Medicare Demonstration Plans." This guide walked plans through the submission process and provided step-by-step instructions on how to prepare and submit encounter data through existing fee-for-service processes.

2. **Incomplete data due to managed care contracting arrangements.** For most plans, data completeness was problematic because the plans did not pay their providers based on the submission of complete and accurate fee-for-service claims data. This issue was particularly troublesome for plans that paid some of their providers under a capitated arrangement. In these cases, not all providers had incentive to submit claims with complete fee-for-service payment information. In addition, many plans did not have financial incentives or enforceable contractual requirements in place to mandate that providers submit data for all services rendered. Consequently, many health plans failed to collect some of the data elements that CMS uses to regulate service quality among fee-for-service providers. Commonly missing data elements included CLIA numbers, ICD-9 procedure codes, and Certificates of Medical Necessity. Lastly, depending on the relationship between plans and their providers, in some cases, it was not possible to obtain missing claim information from providers once plans realized the information was needed. Providers and plan staff often did not have sufficient resources to track down missing data once a claim had already been submitted to the plan, processed, and paid. Medstat helped plans address the issue of missing data by working with them to calculate missing data values or apply CMS-approved default values, as available.

3. **Information system limitations, incompatible file formats, and limited programming expertise.** Most plans participating in the Choices Demonstration used claims processing systems that were incapable of storing complete claims information. Instead, these systems were designed for processing managed care claims. The systems had no capacity for automatically generating electronic or paper claim formats. As a result, plans needed to create stand alone programming to pull data from their claims processing systems and format these data into electronic UB-92 and HCFA 1500 claim formats. In many cases, because the system did not store complete claims information, plans were required to create additional programming to calculate or default missing claim fields as needed. Most plans had difficulty with this exercise due to limited programming proficiency, inexperience developing and testing extract programming, and difficulty interpreting claim specifications. Medstat helped plans with their programming difficulties by assisting plans in interpreting and applying submission specifications, researching and supplying specific default values and programming

algorithms that plans could apply to their submission files, and reviewing submission code and related error reports, as needed, to advise plans on how to correct their submission code.

4. **Difficulties with fiscal intermediary and carrier communications.** Nearly every plan had difficulty establishing submission processes with their fiscal intermediaries and carriers. The root cause of this difficulty seemed to be that fiscal intermediaries and carriers are expert at processing fee-for-service claims from providers; however, they were not prepared to address the volume and complexity of submission issues that plans faced. As such, the plans could not resolve billing problems through the usual billing support channels. Instead, it was ultimately necessary for fiscal intermediaries and carriers to designate selected staff to work with the plans on their submission efforts. These staff often needed to educate plans on the nuances of fee-for-service billing, manually process claims on behalf of the plans, and find ways to override their system to allow plan claims to bypass certain edits that were inappropriate for encounter data (e.g., timely filing edits). An additional complication was that fiscal intermediaries and carriers provided remittance notices back to the plans in formats that were difficult to read without the appropriate translation software and expertise. Thus, plans often required customized reports and special assistance to understand why certain claims were rejected and what needed to be done to correct and resubmit these claims. Medstat assisted the plans with these interpretation difficulties by facilitating communication between the plans and their fiscal intermediaries and carriers and by working with plans to ensure that their issues were adequately addressed.

Issues Impacting All Plans

Beyond the general submission challenges described above, plans also faced other issues that affected their ability to submit accurate and complete claims data. These issues were caused by differences in how plans capture and store encounter data relative to how a provider does. The following issues were particularly problematic:

1. Fee-for-service edits on professional service claims that created difficulty submitting certain claim types including the following:

5. CLIA numbers – these were needed to process all laboratory claims. Most plans did not collect or retain CLIA numbers for their providers. In some cases, it was possible to program a crosswalk into the submission file that mapped CLIA numbers by provider. For plans who had only one major hospital in their network (e.g., St. Joseph's), they submitted all claims with the CLIA number for that hospital. Missing CLIA numbers caused many laboratory claims to reject. In most cases, these claims were never corrected and resubmitted, thus laboratory claims data is generally incomplete for the demonstration plans.

    - Mammography Certification Numbers – All professional claims for mammography services must be submitted with a mammography certification number. United Health Care (UHC) devised a process for assigning a mammography certification number to the plan's submitter ID, which enabled plans submitting their data through UHC to have these claims processed. Some other carriers agreed to follow UHC's process; however, not all plans were successful in submitting claims for mammography services and these data are incomplete.

    - Modifiers – Many professional claims require modifiers that further describe the service in order to price claims accurately. Plans submitted these data whenever they were available. In some cases, plans were successful at correcting and resubmitting claims that rejected due to missing modifiers; however, other plans did not address claims that were rejected due to this error.

- Medicare Secondary Payer – Carriers automatically edited claims to determine if Medicare was the patient's secondary payer insurance In cases where a patient was working aged or had other insurance primary to Medicare, the claim was accepted and processed into the NCHF as a denied claim. Thus, the claim information can be viewed, but the pricing information is inaccurate. Because most Choices Demonstration members have Medicare as their primary insurance, this edit only affected a small portion of claims.

- UPINs – Some of the plans did not collect UPIN information for their providers. Because Medicare professional service claims could not be processed without UPIN information, plans that did not collect UPINs needed to either obtain this information from their providers or to purchase CD-ROMs containing UPIN information and map the data to the provider numbers available in their system. On institutional claims, plans often used the default UPIN number of OTH000 in lieu of valid UPINs if these were not readily available in their encounter data.

2. Fee-for-service edits on institutional service claims that created difficulty submitting certain claim types including the following:

    - Value Codes – These codes are used to relate amounts or values to identify data elements necessary to process claims for Medicare. The use of these codes was conditional and was required only with certain bill types. Plans were able to default value codes for certain services such as physical therapy visits, occupational therapy, and cardiac rehabilitation. However, other plans had claims reject for missing value codes where it was not possible to assign a value code based on other information present on the claim. In those cases, some plans attempted to obtain value code information and resubmit the claim; however, others were unable to submit the encounter successfully.

    - Modifiers – Similar to professional service submissions, some institutional claims require modifiers for the claim to be processed and priced accurately. Some claims were rejected where modifiers were unavailable. In many cases these claims were not successfully resubmitted by plans.

    - Non-covered services – Because Medicare Demonstration plans authorized or provided services that are not covered by fee-for-service Medicare, plans had some encounters that could not be processed by fiscal intermediaries because they were rejected by the system as non-covered.

    - Medicare Secondary Payer – Some Choices Demonstration members had insurance coverage primary to Medicare. Encounter data for these members were rejected by the fiscal intermediary. In some cases, plans were able to work with their fiscal intermediaries to process these claims. However, other plans were not able to set up such processes and thus were unsuccessful in submitting claims for these patients, thereby reducing encounter data completeness.

    - Three-day qualifying stays for SNFs – Generally Choices Demonstration plans did not require a three-day qualifying hospital stay for Skilled Nursing Facility (SNF) visits. Because a three day qualifying stay is a mandatory requirement to cover a fee-for-service SNF stay, plans that either did not supply qualifying hospital stay information or did not require a qualifying hospital stay were unsuccessful in having their SNF claims processed by their fiscal intermediaries. As a result, SNF encounters for most plans are significantly underreported.

3. Diagnoses coded to the highest level of specificity – A common problem for most plans, particularly during the first two years of the demonstration when plans were not experienced with Medicare billing requirements, was obtaining diagnosis codes from providers at the highest level of specificity. This requirement affected both professional and institutional claims. Claims were rejected for plans that were unable to obtain complete diagnosis codes from their providers. These claims were not readily corrected and resubmitted in most instances because of the difficulty in obtaining the complete diagnosis information either from the provider or from information the plan had on file.

4. Setting up provider payment profiles – Many plans had claims for providers that were outside of their local area as a result of members receiving services beyond the plan's geographical region. Fiscal intermediaries did not have access to provider payment profiles for providers outside of the fiscal intermediary's state, though some information for acute care hospitals is available online. To obtain this information, fiscal intermediaries needed to contact out-of-state fiscal intermediaries and wait for a response. For some plans with many out of state encounters, the delay in obtaining these provider profiles exceeded the submission cut-off of December 31, 2000, and encounters could not be submitted.

5. Reconciling submitted claims – In order to ensure that submitted claims were accurately processed and accepted into the National Claims History File (NCHF), it was necessary for plans to review error reports and to correct and resubmit rejected claims based on the reason for the error. Nearly every plan had significant difficulties with this process. Most plans had trouble establishing a system to reconcile submitted claims against error reports and all plans experienced some level of difficulty interpreting error reports and determining how to correct claims. As a result, claims that were initially rejected were far less likely to be resubmitted and accepted into the NCHF.

6. Submission cut-off as of December 31, 2000 – For plans that were transitioning to the M+C program, their Choices Demonstration status ended December 31, 2000. These plans included Health Alliance, Health Partners of Philadelphia, Independence Blue Cross, Mount Carmel, and People's Health Network. The Common Working File only recognizes one H number per plan and that H number designates plan type. Because M+C plans were not permitted to submit through fee-for-service channels, claims submitted after December 31, 2000 were automatically rejected. All transitioning demonstration plans failed to submit all of their outstanding claims by this deadline, and thus, the NCHF data for these plans are incomplete.

Specific Issues by Plan

Though the issues described here generally affected all plans to some degree, each plan was unique in terms of the specific issues that the plan encountered and their corresponding degree of ability to submit complete and accurate encounter data to CMS. The following sections describe specific submission issues for each of the plans that submitted some encounter data to CMS. The information provided for each plan includes an overview of their data capture practices, a review of data completeness issues, a description of issues that affected their submission efforts, workarounds used by the plan, and a description of encounters excluded from the NCHF. This information was obtained through our regular contact with the plans in the course of providing technical assistance for their submission efforts.

To validate our information, we also contacted each plan in the spring of 2001 and reviewed a series of questions with them regarding their data collection efforts and submission challenges. A copy of the discussion guide used for this effort can be found in Appendix A of this report. We have also provided a detailed review of specific workarounds that each plan applied to required submission fields where data were not available (see Appendix B).

Health Alliance Medical Plan

Data Capture Practices

HAMP was successful in capturing data needed to submit encounters to CMS by employing the following practices:

- Providers submitted claims to the plan using standardized UB-92 and HCFA 1500 claim forms;
- The plan instructed their providers to submit claims to the plan as though they were billing fee-for-service Medicare;
- The plan's capitation arrangement with their providers included a year-end reconciliation that provided an incentive for their providers to submit all encounter data to the plan;
- The plan updated their processing system to facilitate the capture of all required data elements.

Data Completeness

As of July 2002, HAMP's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	100.00%	0.00%	91.25%
1998	54.70%	2.21%	161.68%
1999	73.58%	5.35%	104.67%
2000	61.98%	10.66%	70.27%

Note: HAMP's first day of Medicare Choices enrollment was December 1, 1997. The plan stopped participating in the demonstration on December 31, 2000.

Inpatient:

Data processing issues with the plan's fiscal intermediary may have affected the data completeness for this plan; however, the quality of the data that was successfully posted to the NCHF is good. The plan's editing process successfully rejected claims that did not meet their front-end processor criteria. The edits included checks for diagnosis and procedure code specificity and appropriateness. Data that posted to the NCHF included up to 9 diagnosis codes where present because their system stores up to 10 diagnosis codes in total. The data also contain valid procedure codes because the plan's system validates the codes upon entry into the system.

HAMP was able to successfully submit many of the required data elements, including condition codes, value codes, and most revenue codes that were submitted on claim forms. HAMP did strip some revenue codes for non-covered services. These non-covered services include: take home and experimental drugs, acupuncture, ambulance services, general classification drugs, drugs requiring detailed coding, and patient convenience services.

Outpatient:

The plan's poor outpatient data completeness rates were largely the result of one major issue. The plan did not collect HCPCS codes for a 16-month period, dating from December 1997 through February 1999. The plan received permission from CMS to forgo the collection and submission of the claims that were missing HCPCS codes. CMS expected to receive approximately 7,500 outpatient claims from the plan for this time period. The plan also experienced difficulty submitting HCPCS data through their fiscal intermediary, encountering invalid HCPCS code errors. As a result, many of those claims were rejected,

and the plan was unable to obtain the missing HCPCS information in time to resubmit the claims. Lastly, the plan focused resubmission efforts on their inpatient data, further limiting their data completion rates for their outpatient data.

Data that do appear in the NCHF contain relatively accurate information for the services rendered including up to 9 diagnosis codes, accurate revenue and procedure codes, and valid occurrence and condition codes.

Professional Services:

Data that posted to the NCHF included valid accident/symptom date, initial treatment date, CLIA numbers for lab services, place of service information, ambulance data and line charge data. Based on the plan's service delivery model, data completeness rates exceed expected fee-for-service utilization. In spite of these high completeness rates, the plan's professional service claim submissions are incomplete because the plan was unable to correct and resubmit all rejected or denied claims before the submission cut-off date.

Durable Medical Equipment (DME) Claims:

The plan was successful in submitting many of their DME claims data to CMS. The plan reported that they had large volume of DME claims to submit and did not encounter major problems with the submission of these data.

Issues that Impacted Data Submission

HAMP encountered several issues with AdminaStar, their fiscal intermediary. Specifically, the plan cited the submission of HCPCS codes, provider numbers, and Medicare as Secondary Payer (MSP) claims as being problematic with the fiscal intermediary.

The plan did not collect HCPCS data from December 1997 through February 1999, and was subsequently allowed to disregard the submission of these claims. As a result, the completeness of their outpatient data submissions is poor.

Services Excluded from the National Claims History File

HAMP did not submit some services to CMS as part of the Medicare Choices Demonstration. These services were either not covered by Medicare and thus not accepted by the plan's fiscal intermediary/carrier for processing or were rejected by the plan's fiscal intermediary and carrier for missing data. These services include SNF services without 3-day qualifying stay, preventive care, and one-day stays (observation rooms).

Health Partners of Philadelphia

Data Capture Practices

Health Partners had mixed success in submitting encounter data to CMS. Data capture practices that impacted the plan's submission efforts included the following:

- In 1997 the plan allowed providers to submit data on encounter forms rather than using claim forms. The encounter forms did not require all of the data elements to submit encounters to CMS. The plan started requiring claim forms in 1998, which improved overall data capture;
- In 1997, the plan converted their processing system to one that had fields for all standard UB92 and HCFA 1500 data elements. The old system did not enable complete claims data to be entered into the system;
- The plan's primary care physicians were capitated. Before 1998, data capture for these physicians was very poor. When the plan began requiring physicians to use HCFA 1500 forms in 1998, data capture improved, but not all physicians complied with the reporting requirements;
- Because Health Partners was physician-owned, the plan allowed some physicians to submit professional services on UB-92 claim forms. This caused some problems submitting institutional claims and reduced the number of physician services successfully reported.

Data Completeness

As of July 2002, Health Partners' approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	79.13%	46.76%	27.14%
1998	81.15%	62.06%	44.30%
1999	79.70%	58.18%	41.54%
2000	51.55%	36.15%	25.78%

Note: Health Partners' first day of Medicare Choices enrollment was May 1, 1997. The plan stopped participating in the demonstration on December 31, 2000.

Inpatient:

Data posted to the NCHF are not fully representative of all inpatient services the plan provided. Some 1997 data were lost when the plan converted to a new processing system and the plan had insufficient resources available to correct and resubmit claims that rejected due to edits.

Data that are present are of mixed quality. Health Partners is a physician-owned health plan, and did not require all charges to be submitted in a standard Medicare format. The most problematic encounter submissions were professional service claims submitted in a UB-92 format that should have been submitted on a separate HCFA 1500. The plan also paid claims that had incomplete data. This resulted in missing data needed to submit claims through the fee-for-service system.

Outpatient:

Outpatient claims posted to the NCHF do not represent all outpatient services provided by the plan. The plan was missing several data elements needed to successfully submit outpatient claims through the fee-for-service submission channel. Furthermore, the plan did not require that all procedure codes be current. Thus, some claims were rejected by the plan's fiscal intermediary because a procedure code was not valid

for the date of service submitted. The plan was also lacking other edits on their encounter processing system that enabled them to pay claims with incomplete data. This lack of complete data resulted in several rejected claims when the plan attempted to submit data to CMS. The data that are present in the NCHF are generally of good quality; however, they do not fully represent all of the outpatient services rendered to Health Partner members.

Professional Services:

Health Partners data completeness for professional service claims is poor, primarily because the plan did not mandate submission of encounters for all professional services rendered. Providers decided what claim format they wanted to use to submit their encounters. This resulted in several incomplete encounters records that could not be processed by the plan's carrier. Furthermore, the plan did not have staff available to review and process rejected claims.

Durable Medical Equipment (DME) Claims:

The plan did not submit any claims for DME services.

Issues that Impacted Data Submission

The plan had several issues that impacted their ability to submit complete encounter data. These issues included the following:

- System problems and a system conversion that resulted in very poor data for 1997 and 1998, but improving data quality and completeness in 1999 and 2000, as the result of more robust claim editing processes;
- Plan's providers often did not submit complete data using standard formats;
- Plan had limited resources available to correct and resubmit rejected or denied claims;
- Plan required extensive use of workarounds to address missing data.

Services Excluded from the National Claims History File

Because the plan was unable to convert much of its encounter data from its old system to its new system, claims data from 1997 and 1998 is largely incomplete. Physician claims are particularly problematic because these encounters were not submitted regularly on standard claim formats. All claims for patients with Medicare as a secondary coverage were submitted as though Medicare were primary. These claims were rejected by the plan's fiscal intermediary and were denied and priced at zero by the plan's carrier. Lastly, the plan did not successfully submit any of the following claims: SNF stays without a 3-day qualifying stay, claims for preventive care services, and DME claims.

Health Plans of Pennsylvania (formerly Crozer-Keystone)

Data Capture Practices

Relative to some of the other plans, Health Plans of Pennsylvania was successful at submitting their encounter data to CMS for 1997 and 1998. With approval from CMS, the plan was not required to submit encounter data for 1999 dates of service, and thus, no data are available for that year. The plan's submission success was the result of the following data capture practices:

- The plan used SMS, an experienced billing organization, to submit their encounter data on the plan's behalf;
- The plan's data capture system was able to accept all UB-92 and HCFA 1500 data elements;
- Approximately 99% of all encounters submitted to the plan were on standard UB-92 or HCFA 1500 claim forms. Some superbill forms were also submitted; however, these generally contained all of the data elements needed to submit the claims through a fee-for-service system;

- The plan had appropriate front-end edits to ensure that data were complete and accurate before processing claims.

Data Completeness

As of July 2002, Health Plans of Pennsylvania's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	100.37%	92.90%	152.29%
1998	84.51%	61.00%	86.58%
1999	0.08%	0.00%	0.00%
2000	0.00%	0.00%	0.00%

Note: Health Plans of Pennsylvania's first day of Medicare Choices enrollment was April 1, 1997. The plan stopped participating in the demonstration on December 31, 1999.

Inpatient

Based on the data capture practices described above, Health Plans of Pennsylvania inpatient data are largely complete. The plan estimates that up to 5% of their inpatient claims were not successfully processed by their fiscal intermediary. These claims were submitted to CMS in a separate flat file, but are not available in the NCHF. Because the plan had good data collection practices and appropriate billing expertise, the quality of submitted inpatient data is good.

Outpatient

Similar to the plan's completeness rate for inpatient claims, the plan's outpatient claims for 1997 and 1998 are also largely complete. The plan estimates that up to 5% of their services may not be represented in the NCHF, but otherwise, the data posted to the NCHF accurately reflect outpatient services provided by the plan.

Professional Services

The only completeness issue cited by the plan related to their professional service submissions. The plan had difficulty submitting claims for mammography services because mammography certification numbers were not available. However, in reviewing the plan's data completeness estimates, it is apparent that data submitted in 1998 is less complete than data submitted for 1997. The difference in data completeness results by claim type is because the plan focused their 1998 submission efforts on inpatient and outpatient claims rather than professional service claims. Professional services, that were either denied or rejected, were unlikely to be corrected and resubmitted for 1998.

Durable Medical Equipment (DME) Claims:

The plan successfully submitted DME claims with no reports of submission difficulties.

Issues that Impacted Data Submission

The plan experienced no significant issues that impacted their data submission efforts. They had some initial communication difficulties between their billing vendor and their fiscal intermediary and carrier; however, all of these issues were ultimately resolved.

Services Excluded from the National Claims History File

Because the plan's care delivery model predominantly featured services that were covered by fee-for-service Medicare, the plan did not have groups of services systematically excluded from the NCHF.

Humana of Houston (formerly Memorial Sisters of Charity)

Data Capture Practices

Humana of Houston (HOH) did not capture all of the essential data elements required for Choices Demonstration submissions. The plan's system did not have the capacity to store all of these elements, and the plan did not attempt to upgrade their system to meet these requirements. The plan was able to submit encounter data to CMS using approved workarounds to circumvent fee-for-service processing edits.

Data Completeness

As of July 2002, HOH's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	82.18%	0.00%	96.35%
1998	104.02%	0.00%	99.93%
1999	100.67%	0.00%	108.03%
2000	60.17%	0.00%	84.93%

Note: HOH's first day of Medicare Choices enrollment was April 1, 1997. The plan stopped participating in the demonstration on December 31, 2000.

Inpatient:

HOH experienced considerable difficulty developing programs in order to submit files for their Choices encounter data. However, the plan approached the expected submission targets through the use of CMS-approved workarounds and through significant intervention on the part of their fiscal intermediary to manually process claims on the plan's behalf. In addition, the plan stripped all ancillary services from their inpatient claims to enable the claims to bypass the majority of edits. In spite of these steps to streamline the submission process, the plan still experienced some rejected claims that needed to be corrected and resubmitted. The plan had considerable difficulty interpreting error reports received from their fiscal intermediary. However, with assistance from Medstat and their fiscal intermediary, the plan was ultimately able to correct and resubmit the majority of rejected claims.

Outpatient:

HOH was unsuccessful at submitting outpatient encounter data for their Choices Demonstration because the plan did not capture HCPCS codes in their encounter processing system. At CMS' request, the plan ultimately submitted all of their outpatient data directly to CMS in a simplified flat file format. These data do not appear in the NCHF.

Professional Services:

The plan was able to submit the majority of their professional service claims through the use of CMS-approved workarounds that were applied where required data were missing. The plan encountered difficulty identifying, correcting, and resubmitting rejected claims so the data are not 100% complete.

However, the data that posted to the NCHF do include valid diagnosis codes, line charge data, and place of service.

Durable Medical Equipment (DME) Claims:

The plan did not submit any DME claims to their DME carrier prior to the termination of the Choices Demonstration on December 31, 2000.

Issues that Impacted Data Submission

HOH faced several challenges that affected their submission efforts. The plan's claims processing system did not meet the requirements for data capture to generate claims that could be submitted through a Medicare fee-for-service system. Some of the data elements not captured by their system did not have workarounds available. The plan was also unable to create submission programming that worked reliably and encountered several delays as they worked to create submission files. In addition, the plan could not reconcile the claims that were submitted to their fiscal intermediary and carrier, nor were they able to efficiently interpret error reports and apply the changes required for resubmission. Many claims were left as rejected and not resubmitted. These claims were subsequently sent to CMS in a simplified flat file format. Common errors encountered by the plan included eligibility errors, provider identification issues, missing data issues, and general programming errors.

Services Excluded from the National Claims History File

HOH did not submit some services to CMS as part of the Medicare Choices Demonstration. These services were either not covered by Medicare and thus not accepted by the plan's fiscal intermediary/carrier for processing, or because the plan had incomplete encounter data and could not be processed. These services include inpatient ancillary services, laboratory claims data, SNF services without qualifying 3-day stay, mammography services, and DME claims.

Independence Blue Cross of Philadelphia

Data Capture Practices

Independence Blue Cross of Philadelphia (IBC) succeeded in capturing data needed to submit encounters to CMS by employing the following practices:

- Providers submitted claims to the plan using standardized UB-92 and HCFA 1500 claim forms;
- The plan instructed their providers to submit claims to the plan as though they were billing fee-for-service Medicare;
- The plan's fee-for-service arrangement with their providers requires that the provider submit claims in order to receive payment for services provided.

Data Completeness

As of July 2002, IBC's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	52.25%	60.56%	105.80%
1998	58.71%	82.70%	174.48%
1999	67.06%	82.37%	219.06%
2000	46.34%	57.59%	56.97%

Note: IBC's first day of Medicare Choices enrollment was April 1, 1997. The plan stopped participating in the demonstration on December 31, 2000.

Inpatient:

IBC's data completeness percentages are relatively low due to data processing issues with the plan's fiscal intermediary. The fiscal intermediary was not able to successfully process approximately 500-700 inpatient and/or outpatient claims due to difficulties in collecting the provider information required to accurately price the claims. However, the quality of the data that successfully posted to the NCHF is good. Data that posted to the NCHF included up to 9 diagnosis codes where present because their system stores up to 10 diagnosis codes in total. The data also contain valid procedure codes because the plan's system validates the codes upon entry into the system.

IBC was able to successfully submit many of the required data elements for their inpatient data, including value codes and revenue codes that were submitted on claim forms. However, the plan did strip claims containing revenue code 636 (drugs requiring detailed coding) from their inpatient submissions. IBC did not submit Skilled Nursing Facility claims due to an edit at the Common Working File that requires that a qualifying hospital stay exist prior to the dates of service for these claims. IBC does not have the same requirements for their members, thus the qualifying stay was not available for submission to CMS.

Outpatient:

IBC was reasonably successful in submitting their outpatient data. As noted above, the fiscal intermediary was not able to process a number of outpatient claims due to provider information issues. The plan also stripped data from some of their claims in order for them to process through their fiscal intermediary's system. Specifically, the plan stripped occurrence codes, value codes, and some revenue codes from their outpatient claims.

Data that do appear in the NCHF contain relatively accurate information for the services rendered including up to 9 diagnosis codes, accurate revenue, HCPCS and procedure codes, and valid condition codes.

Professional Services:

The plan encountered difficulties transitioning the submission of professional services data to a new carrier during the last six months of the demonstration. The data for this time period were subsequently submitted to CMS in a flat file and do not appear in the NCHF. Data that posted to the NCHF included diagnosis codes, line charge data, and place of service. The plan was authorized to use multiple workarounds for the submission of their professional services data, including defaulting the provider name if it was not provided in the original claim. To enable easier reconciliation of submitted claims, the plan submitted individual line items on a claim as separate claims. This practice resulted in inaccurate data completeness rates, which appear higher than the plan's actual data completeness.

Durable Medical Equipment (DME) Claims:

The plan was unable to submit DME claims to their DME carrier prior to the termination of the Choices Demonstration on December 31, 2000.

Issues that Impacted Data Submission

IBC encountered several issues with their fiscal intermediary, Veritus. The plan reported that the fiscal intermediary was not helpful in resolving several errors that they encountered during the submission process, including the Provider Information errors referenced above. The plan was successful in submitting professional services data to their original carrier, UHC; however, the plan was not successful in transitioning the submissions to Trailblazer Healthcare Enterprises (TBHE) when TBHE took over as the carrier for IBC in September of 2000.

Services Excluded from the National Claims History File

IBC did not submit some services to CMS as part of the Medicare Choices Demonstration. These services were either not covered by Medicare and thus not accepted by the plan's fiscal intermediary/carrier for processing or because the plan had incomplete encounter data and the claims were rejected by the plan's fiscal intermediary and carrier for missing data. These services include SNF services without 3-day qualifying stays.

Mount Carmel Health Plan

Data Capture Practices

Mount Carmel Health Plan (Mount Carmel) did not capture some data elements that were required for Choices Demonstration submissions. However, the plan was able to collect data from most of their providers by requiring providers to submit claims to the plan using standardized UB-92 and HCFA 1500 claim forms. Unfortunately, the plan was largely unsuccessful at submitting encounter data to CMS due to difficulties developing submission programming. Initially, the plan employed the vendor of their encounter processing system to develop the submission programming on their behalf. When this vendor was unable to complete the effort, the plan decided to program the files in-house. However, programming was not completed for all claim types before the end of the demonstration on December 31, 2000.

Data Completeness

As of July 2002, Mount Carmel's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	8.11%	0.00%	29.99%
1998	19.15%	0.00%	10.58%
1999	28.83%	0.00%	0.00%
2000	19.53%	0.00%	0.00%

Note: Mount Carmel's first day of Medicare Choices enrollment was April 1, 1997. The plan stopped participating in the demonstration on December 31, 2000.

Inpatient:

Mount Carmel encountered great difficulty successfully programming the creation of submission files for their Choices encounter data. This directly impacted the plan's ability to meet the targets for data submission. Overall data completeness is poor because the plan did not finish developing the programming specifications before the submission cut-off.

Mount Carmel claims with dates of service prior to September 1998 do not contain procedure codes because these were not recorded in the plan's claims processing system. These claims were submitted using a CMS approved workaround that allowed the claims to process without the procedure codes. A large percentage (approximately 50%) of the claims that posted to the NCHF for Mount Carmel are questionable due to uncertainty about their submission dates and submission source. The plan had intended to audit the files to ensure that the data are accurate, however, there is no indication that this audit took place.

Outpatient:

Mount Carmel did not successfully submit outpatient encounter data for their Choices Demonstration. CMS waived the plan's requirement to submit these data because the data were not needed to determine the plan's reimbursement.

Professional Services:

The plan did not successfully submit professional services data for claims with dates of service in 1999 or 2000. The data that did post to the NCHF for 1997 and 1998 dates of service contain CMS approved workarounds for the submission of their professional services encounter data. However, the data do include diagnosis codes, line charge data, and place of service. Furthermore, these data were submitted to the carrier before CMS-approved workarounds were available for missing data. Thus, many claims submitted at that time could not be successfully processed.

Durable Medical Equipment (DME) Claims:

The plan was not able to successfully submit DME claims to their DME carrier prior to the termination of the Choices Demonstration on December 31, 2000.

Issues that Impacted Data Submission

Mount Carmel's claims processing system did not meet some of the requirements for data capture to generate claims that could be submitted through a Medicare fee-for-service system. The plan upgraded their systems to capture more information, however, the plan also encountered major difficulties setting up programs to successfully submit Choices encounter data to CMS. The plan also had considerable difficulty meeting the requirements of fee-for-service submissions. In particular, they had marginal success at developing submission specifications, and virtually no success at resolving several errors that they encountered during the submission process in spite of considerable assistance from Medstat, including multiple reviews of the plan's submission code. The plan appeared to have limited resources available to apply to this effort, and thus, simply ran out of time to submit data to CMS before the demonstration ended.

Services Excluded from the National Claims History File

Mount Carmel Health Plan did not submit some services to CMS as part of the Medicare Choices Demonstration. These services were either not covered by Medicare and thus not accepted by the plan's fiscal intermediary/carrier for processing, or because the plan had incomplete encounter data and the claims were rejected by the plan's fiscal intermediary and carrier for missing data. These services include chiropractic claims data, ambulance services, outpatient institution claims, laboratory data, SNF services, home health services, and DME claims.

People's Health Network

Data Capture Practices

People's Health Network (PHN) was generally successful in capturing data needed to submit encounters to CMS by employing the following practices:

- The plan's providers submitted claims to the plan using standardized UB-92 and HCFA 1500 claim forms;
- The plan instructed their providers to submit claims to the plan as though they were billing fee-for-service Medicare;
- PHN rejected fee-for-service claims if critical data fields were missing. To get reimbursed, providers were required to resubmit claims with complete information;
- The plan used AMISYS as their encounter data processing system. This system had the capacity to store most of the data elements that appear on a standard UB-92 or HCFA 1500;
- Though 20% of PHN's physicians were capitated, the plan tied payment incentives to each physician's utilization rate, which resulted in good encounter data reporting.

Data Completeness

As of July 2002, PHN's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	100.00%	44.33%	88.96%
1998	54.97%	34.54%	85.95%
1999	73.88%	29.75%	82.97%
2000	36.41%	16.76%	59.47%

Note: PHN's first day of Medicare Choices enrollment was September 1, 1997. The plan stopped participating in the demonstration on December 31, 2000.

Inpatient:

Inpatient data completeness is problematic for PHN due to issues the plan had with their fiscal intermediary processing their claims. Of the data that are present, the data quality is relatively good. Data that posted to the NCHF included up to 9 diagnosis codes where present because Amisys has the capacity to store up to 10 diagnosis codes in total. The data also featured valid procedure codes because the plan's Amisys system validated the codes upon entry into the system.

Other data that posted to the NCHF consisted of valid procedure dates, condition codes, value codes, and most revenue codes that were submitted on claim forms. Due to various edits that were causing some claims to reject, PHN did strip some ancillary revenue codes from their inpatient claims for the following types of services: pharmacy, ambulatory surgery, outpatient services, drugs requiring detailed coding, treatment or observation rooms, preventative care, and physician fees. It was necessary for PHN to remove those revenue codes, some of which were inappropriate for an inpatient bill type, in order to have the inpatient claim processed.

PHN did use some workarounds for other data elements that were required, but not available in their system. These included default values for type of admission, source of admission, and Medicare

Secondary Payer (MSP) information. Because the plan had less than 1% of their members with insurance primary to Medicare, the impact of using MSP default values would have affected less than 1% of the plan's claims.

Outpatient:

The plan's outpatient data completeness is poor because of two major issues the plan had submitting these data. The first issue was that the plan did not capture HCPCS codes on up to 60% of their outpatient claims. As a result, all of those claims were rejected, and the plan was unable to obtain the missing HCPCS information in time to resubmit the claims. The second major issue was that the plan was unsuccessful in correcting and resubmitting any outpatient claims to its fiscal intermediary due to problems with the fiscal intermediary's system in recognizing the corrected claims as replacement claims. As a result, PHN's outpatient data are insufficiently representative of all of the outpatient services the plan provided its members. Data that do appear in the NCHF contain relatively accurate information for the services rendered including up to nine diagnosis codes, accurate revenue and procedure codes, and valid occurrence and condition codes. The plan did apply some default values that were needed, including type of admission, source of admission, and value codes.

Professional Services:

Professional service data that posted to the NCHF included valid accident/symptom date, initial treatment date, CLIA numbers for lab services, because these were required as part of PHN's provider enrollment process, place of service information, and charge information. The plan's data completeness was affected by the fact that PHN did not resubmit any of the rejected claims because their concentration was on their inpatient submissions. The plan estimated that their overall claim reject rate was approximately 15-20% of all professional claims submitted. In addition, the plan did not submit any Not Otherwise Classified Codes, ambulance services, or laboratory claims. The plan believes that all ambulance services may have been billed on a UB-92, and thus, these services may appear in the plan's institutional data. For laboratory claims, because the plan capitated their lab provider, they did not have sufficient information to submit lab claims through the fee-for-service processing system.

Durable Medical Equipment (DME) Claims:

The plan was successful in submitting approximately 40% of their DME data to CMS. The plan had major issues obtaining modifiers from their DME providers, which hindered their ability to submit complete data. In addition, Palmetto, the plan's DME carrier, was unable to accept any claims from PHN for over a year, due to the carrier's efforts to prepare for Y2K. As a result, the plan did not submit all of their claims before the December 31, 2000 cut-off.

Issues that Impacted Data Submission

PHN concentrated its efforts primarily on the submission of inpatient data for 1997-1999. The plan encountered many problems with their inpatient submissions because of Trispan, the plan's fiscal intermediary. PHN had many of their inpatient claims reject because Trispan had difficulty adding PHN's providers to their system. As a result, many claims were not submitted before the deadline for the demonstration. Another problem PHN encountered during the demonstration was that Trispan deactivated a large amount of their inpatient claims because these claims were suspended in Trispan's system for a long period of time. PHN was only able to resubmit some of these claims to the NCHF; therefore, inpatient data in the NCHF are incomplete.

PHN's outpatient claims were also affected because of the problems with Trispan and prevented PHN from resubmitting any of their corrected claims to CMS. All claims that were resubmitted by PHN have been suspended in Trispan's system and any claims that were resubmitted by PHN rejected as duplicate claims. In addition, PHN's physician claims are also incomplete. PHN concentrated its efforts largely on inpatient submissions and was not able to reconcile their physician claims before the deadline for the

demonstration. Lastly, for DME submissions, PHN was only able to submit 40% of their DME data to CMS in part because the plan's DME carrier did not accept their claims data for over a year. The plan was also missing modifiers needed to submit DME claims.

Services Excluded from the National Claims History File

Some of PHN's services were not submitted to CMS as part of the Medicare Choices Demonstration either because these services are non-covered Medicare services and were not accepted by the plan's fiscal intermediary or carrier for processing, or because the plan had incomplete encounter data and the claims were rejected by the plan's fiscal intermediary and carrier for missing data. The services include SNF services without 3-day qualifying stay, lab, home health, and ambulance services.

Secure Choice Health Plan

Data Capture Practices

Secure Choice Health Plan (Secure Choice) was marginally successful in capturing data needed to submit encounter data to CMS. Due to contracting arrangements with several of the plan's large provider groups, Secure Choice did not receive a large percentage of their expected claims volume. The plan employed the following practices in an effort to ensure that data received met Medicare fee-for-service requirements:

- Secure Choice's providers submitted claims to the plan using standardized UB-92 and HCFA 1500 claim forms;
- Secure Choice's claims processing system was able to store most of the data elements required for fee-for-service submission;
- Providers were instructed to submit claims to the plan as though they were billing fee-for-service Medicare.

Data Completeness

As of July 2002, Secure Choice's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	0.00%	11.11%	69.84%
1998	33.15%	27.05%	95.45%
1999	54.03%	32.50%	47.97%
2000	57.43%	31.05%	65.77%

Note: Secure Choices first day of Medicare Choices enrollment was September 1, 1997. The plan stopped participating in the demonstration on December 31, 2000.

Inpatient:

Secure Choice's data completeness percentages are low due to contracting arrangements with provider groups and data processing issues with the plan's fiscal intermediary. Secure Choice held capitated payment agreements with two major physician groups that accounted for approximately 25% of the plan's membership. The contractual arrangement with these groups did not provide incentive for the groups to participate; therefore, they did not submit encounter data to Secure Choice. The plan's fiscal intermediary did not have an electronic feedback mechanism to allow the plan and its contracted data submission vendor to track claims that were submitted to CMS. This made the identification and correction of claims

that rejected difficult to accomplish. The plan was subsequently allowed to submit outstanding claims directly to CMS using a simplified flat data layout.

Data that posted to the NCHF included up to nine diagnosis codes, where present. The data also contain valid procedure codes because the plan's system validates the codes upon entry into the system. The plan reported that 10 to 15% of their claims contained diagnosis or procedure codes that were not coded to the highest level of specificity.

Secure Choice used many CMS-approved workarounds to submit some of the required data elements for their inpatient data, including value codes and revenue codes.

Outpatient:

Secure Choice was not able to successfully submit a large percentage of their outpatient claims through fee-for-service channels. The plan did not collect both revenue code and HCPCS code in their system. The plan was able to submit some claims that contained HCPCS information by deriving the revenue code from the HCPCS code, but they were not able to submit claims that only contained revenue codes. The plan submitted the majority of their outpatient claims to CMS using a simplified flat data layout that contained a minimal number of variables. These data are not available in the NCHF.

Professional Services:

The plan used CMS approved workarounds for the submission of their professional services encounter data. However, the data that posted to the NCHF included diagnosis codes, line charge data, and place of service. The plan did not submit chiropractic or ambulance services claims.

Durable Medical Equipment (DME) Claims:

The plan was not able to successfully submit DME claims to their DME carrier prior to the termination of the Choices Demonstration on December 31, 2000.

Issues that Impacted Data Submission

Secure Choice encountered several issues that affected their ability to adequately collect and submit encounter data for their Choices membership. The plan's capitation contracts with several large provider groups negatively impacted their ability to collect the expected volume of claims. The plan also encountered several issues with their fiscal intermediary, Blue Cross/Blue Shield of Georgia. The plan reported that the fiscal intermediary was not helpful in resolving several errors that they encountered during the submission process, including resolving provider information errors and providing a mechanism that would allow the plan to effectively reconcile their submissions. The fiscal intermediary provided only paper reports as tools to track the data, which meant all rejected claims had to be manually reviewed and corrected. Because insufficient resources were available for this effort, the plan was unable to correct a significant portion of rejected claims.

Services Excluded from the National Claims History File

Secure Choice did not submit some services to CMS as part of the Medicare Choices Demonstration. These services were either not covered by Medicare and thus not accepted by the plan's fiscal intermediary/carrier for processing, or because the plan had incomplete encounter data and the claims were rejected by the plan's fiscal intermediary and carrier for missing data. These services include chiropractic claims data, ambulance services and DME claims.

St. Joseph's Health Systems

Data Capture Practices

St. Joseph's Health Systems (St. Joseph's) was partially successful in submitting encounter data to CMS. This accomplishment is noteworthy given the significant staff turnover the plan faced throughout this process. Because the plan abandoned the demonstration after a year and half, they had limited opportunity to develop the necessary data collection and submission expertise. The plan also intended to use a billing vendor to create their submission programming. Unfortunately, this vendor went out of business and the plan was unable to leverage progress made by the vendor to complete the submission effort. Ultimately, the plan hired two contract programmers to develop their submission files. The programmers were successful in submitting claims that had complete and accurate data. Claims that rejected were ultimately never accepted into the NCHF because the plan had no staff available to correct and resubmit these claims. Because the plan required that all claims be submitted in a standard UB-92 or HCFA 1500 format, a large portion of claims were processed and posted to the NCHF, but these do not reflect all services provided by the plan.

Data Completeness

As of July 2002, St. Joseph's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	0.00%	0.00%	0.00%
1998	67.36%	4.85%	73.73%
1999	67.67%	3.46%	68.56%
2000	0.00%	0.00%	0.00%

Note: St. Joseph's first day of Medicare Choices enrollment was July 1, 1998. The plan stopped participating in the demonstration on December 31, 1999.

Inpatient:

In general, the simplest inpatient claims were successfully posted to the NCHF. Claims subject to more complex edits, such as those requiring modifiers, condition codes, or value codes, were rejected in the majority of cases due to missing data. The plan's programmer did not calculate default values for many fields where data were missing, which increased the overall rejection rate. Claims data that are present in the NCHF contain few workarounds and are of good quality overall.

Outpatient:

Nearly all of the outpatient claims were rejected by the plan's fiscal intermediary because HCPCS codes were missing. Missing data for these claims were never obtained. CMS ultimately had the plan submit the data directly to CMS using a flat file format.

Professional Services:

Similar to institutional claims, professional claims were incomplete either because data were missing and the plan's programmer did not use available workarounds, or because claims were rejected and no one was available to resubmit them. Professional services claims that did post contained valid diagnosis and procedure information.

Durable Medical Equipment (DME) Claims:

The plan did not submit any DME claims to the NCHF as part of this demonstration.

Issues that Impacted Data Submission

As described above, the plan did not participate in the demonstration for very long. They also experienced substantial staff turnover, which prevented the plan from developing any expertise in navigating the fee-for-service submission environment. Because the plan was able to identify outside programmers with sufficient expertise, the plan was successful at submitting some data to CMS. However, because the plan did not capture all required data in their encounter system, many of these claims rejected. The plan could have corrected and resubmitted most of these claims, however, the plan did not have enough resources to perform this task.

Services Excluded from the National Claims History File

St. Joseph's did not submit any DME, home health, or SNF claims.

UCSD Senior Health Plan

Data Capture Practices

UCSD Senior Health Plan (UCSD) was generally successful in capturing data needed to submit encounters to CMS by employing the following practices:

- Providers submitted claims to the plan using standardized UB-92 and HCFA 1500;
- The plan instructed their providers to submit claims to the plan as though they were billing fee-for-service Medicare;
- The plan rejected fee-for-service claims if critical data fields were missing, and it required providers to resubmit the claims with complete information;
- UCSD used IDX as their encounter data processing system. This system had the capacity to store most of the data elements that appear on a standard UB-92 or HCFA 1500;
- UCSD's reimbursement from CMS included 50% of Medicare cost for inpatient, SNF, and home health services. Thus, the plan had substantial incentive to correct and resubmit rejected claims for these services, which enhanced their data completeness significantly.

Data Completeness

As of July 2002, UCSD's approximate data completeness for claims data posted to the NCHF is shown in the table below. These estimates were calculated using expected utilization based on fee-for-service benchmarks. A discussion of data completeness by claim type is provided below.

Year	Inpatient Data Completeness Estimate	Outpatient Data Completeness Estimate	Professional Services Data Completeness Estimate
1997	0.00%	0.00%	0.00%
1998	114.63%	139.70%	77.09%
1999	118.42%	153.75%	69.97%
2000	88.46%	78.92%	47.39%

Note: UCSD's first day of Medicare Choices enrollment was July 1, 1998. The plan stopped participating in the demonstration on December 31, 2000.

Inpatient:

UCSD's inpatient data completeness was outstanding because the plan's reimbursement was based on the successful submission of these claims. Data that posted to the NCHF included diagnoses codes coded to the fifth digit, valid HCPCS and revenue codes, valid condition codes, procedure codes with all digits because IDX would have rejected the procedure code if all digits are not entered, valid type of bill and value codes, covered days and non-covered days, lifetime reserve days, co-insurance days, admission date, and home health data. The majority of UCSD's inpatient data is complete and accurate since all data submitted to the NCHF were taken directly from claims data, and no Medstat defaults were used to submit the data.

Outpatient:

UCSD's outpatient data completeness estimates are based on Medstat's estimated outpatient service utilization, and are not appropriate for UCSD's service delivery model, which features higher outpatient service utilization. Overall, UCSD focused primarily on inpatient submissions and did not correct and resubmit rejected outpatient claims. Consequently, in spite of the high data completeness estimates, outpatient data in the NCHF are incomplete.

Professional Services:

Professional service data are also incomplete in the NCHF because the plan did not review and correct claims that were rejected for incorrect or missing data. Data in the NCHF include valid accident/symptom date, initial treatment date, diagnoses codes to the fifth digit, CLIA numbers for lab services, place of service information, and charge information.

Durable Medical Equipment (DME) Claims:

The plan did not submit any DME claims to CMS, and thus, there are no claims in the NCHF that reflect DME supplies covered by the plan.

Issues that Impacted Data Submission

UCSD concentrated its efforts primarily on the submission of inpatient data for 1998-2000 because its reimbursement was based on their institutional charges. The plan worked with their fiscal intermediary to resubmit claims with missing data such as HCPCS codes, invalid occurrence codes and span codes, revenue codes, SNF, and home health data. The most problematic issues for the plan were obtaining SNF and home health data elements. Many of the claims did not contain this information and required UCSD to obtain these data from the providers. The plan applied Medstat–recommended defaults only on claims where required data were missing. Thus, most of the data in the NCHF are complete and accurate. The plan reports that they submitted 100% of their inpatient data to CMS by the end of the demonstration project.

For outpatient and physician claims, UCSD was less successful at submitting accurate and complete data. The plan spent the majority of its time on inpatient submissions, and did not correct and resubmit rejected outpatient or physician claims. In addition, UCSD did not apply many of the workarounds and defaults suggested by Medstat for fields in which data were required, which could have caused many of the claims to reject. As a result, UCSD's outpatient claims in the NCHF do not include claims that rejected, and therefore, are not fully representative of outpatient and professional services provided by the plan. Additionally, UCSD discontinued submission of their physician data to CMS as of October 1, 2000 as a result of the transition of their carrier, TransOccidental to NHIC. Any services provided after that date were not submitted to CMS.

Services Excluded from the National Claims History File

Some of UCSD's services were not submitted to CMS as part of the Medicare Choices Demonstration because these services are non-covered Medicare services and were not accepted by the plan's fiscal intermediary or carrier for processing. The services include SNF services without 3-day qualifying stay, DME, pharmacy, preventive care services, and ambulance services.

Florida Hospital, Ohio Health Alliance, and Yellowstone Community Health Plan

Though these plans submitted some data to the NCHF, they dropped out early in the submission process before Medstat began supplying comprehensive technical assistance. Consequently, information regarding their data quality is not available for this report.

III. ANALYSIS OF AGGREGATE PLAN DATA

Against the backdrop of these data submission challenges, plans were able to submit more than 2.5 million claims for services between 1997-2000. While this is a sizeable number, we can compare facets of these claims with similar data collected from the larger Medicare population and draw conclusions as to the completeness and accuracy of the claims data. As discussed in the last section, simply applying 1997 fee-for-service utilization rates to the data received provides a gross indicator that data posted to the NCHF are incomplete relative to services provided.

The purpose of benchmarking these data is to provide a basis for evaluation and comparison of these data against national norms. Using this approach, the norms become a point of reference for the analysis and measurement of the completeness and reasonability of the Medicare Choices pseudoclaims data. For most measures, it is not possible to obtain benchmarks from a population identical to the Medicare Choices Demonstration population. In some cases, fee-for-service benchmarks were available and no managed care benchmark was available. In other cases, benchmarks were constructed using Medicare-only discharge records for nationwide inpatient samples. Our general approach is to identify statistics from populations that are as representative as possible of the Medicare population enrolled in the Medicare Choices program to use as benchmarks for the Medicare Choices Demonstration data.

An underlying principle in our analyses is to perform a relatively small, but focused, set of analyses aimed at answering our basic research question: Are the data complete and accurate? Although we can calculate a large number of measures and compare these results to unreliable benchmarks, this only increases the probability we will find spurious differences and perhaps falsely conclude that plans submitted incomplete or inaccurate data.

Methods, Selection, and Transformations

Data Sources

Data for this report came from four sources. Plan specific data was extracted for the thirteen participating health plans from the NCHF maintained at CMS. The data analyzed covers the 1997-2000 calendar years and includes Medicare Part A and Part B submissions. These data were provided in raw Version I claims format and were unduplicated and adjudicated. Benchmark statistics pertaining to each of the measures were derived using data from the Health Care Financing Review, Statistical Supplement 2000, and the Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project's, Nationwide Inpatient Sample database. Additionally, it was determined that the Medicare Fee-for-Service (FFS) Claims Data are the best available source for benchmarking to the Medicare Choices, absent information from the M+C program. FFS data can provide information on utilization by type of major service (e.g., inpatient, outpatient, physician, home health care, skilled nursing home). Furthermore, data are reported in a similar manner to the Medicare Choices Demonstration. Also, the population enrolled is

likely to be similar to that in the Medicare Choices Program. Finally, data can be adjusted by age, gender, enrollment status, and health status.

The main difficulty with the Medicare FFS claims data for benchmarking is that there are likely to be real differences in utilization rates under the FFS program and under managed care, even after adjusting for population characteristic differences. For example, numerous studies have shown that admission rates are lower under managed care than traditional FFS. Furthermore, billing differences may lead to differences in utilization reporting, for example, lab may be bundled with the physician bill under the FFS program but billed separately under the Medicare Choices program. Unless these are explicitly recognized, real utilization differences between the Medicare Choices population and Medicare FFS population might be erroneously attributed to errors in reporting.

Inclusions

Included in this report is an analysis of all enrollees and encounters across all plans for the 1997-2000 calendar years. Acknowledging that not every participating plan collected or made available enrollment data for all researched years, this report places particular focus on the 1998 calendar year for all participating plans as being the most accurate representation in data submission and participation. For this reasons all benchmarks reflect the 1998 norms for each measure.

Exclusions

After extensive review, it was determined that Home Health/Hospice encounters be excluded from this analysis due to the lack of adequate data to perform a thorough analysis and benchmark studies.

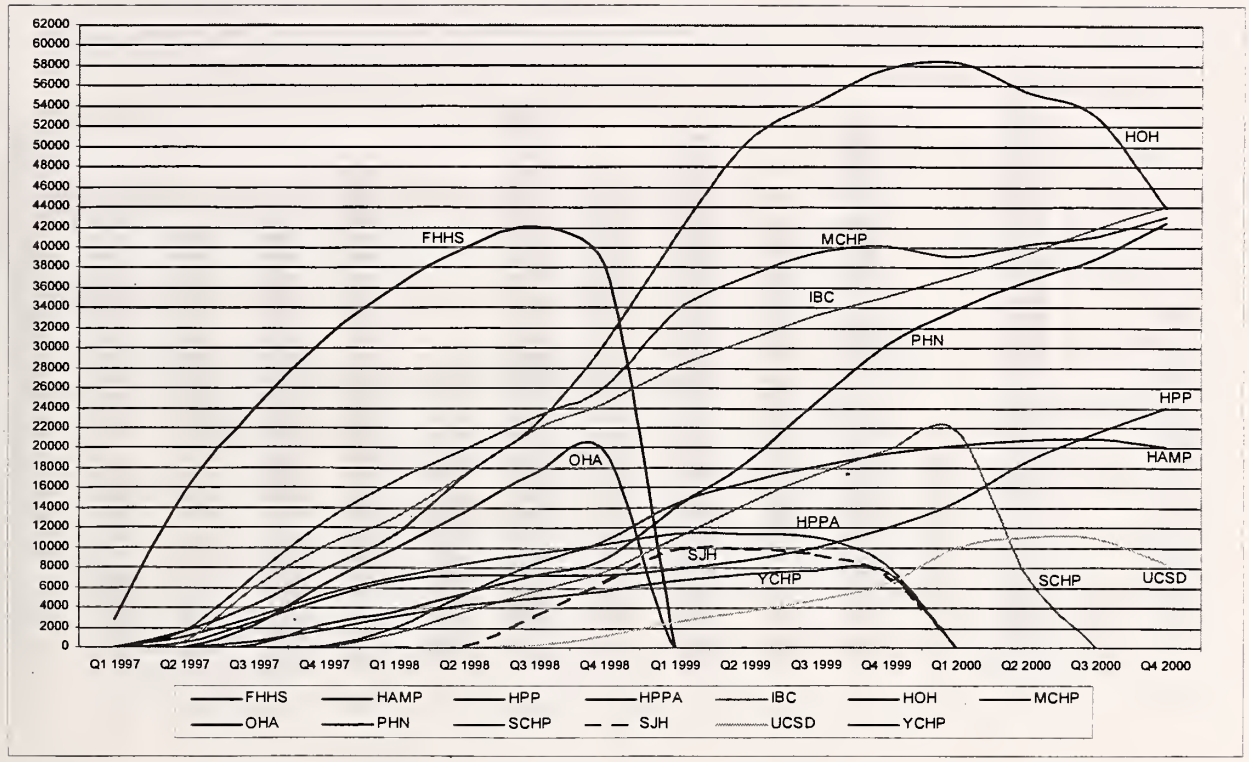
Measures

In this section we describe proposed benchmark categories for the Medicare Choices Demonstration data. Where appropriate, benchmark measures include means and/or rates. These can be calculated as an average or rate for an encounter type, plan, year, enrollee, user, or average for a given encounter type.

Description of Overall Measures

One of the most basic building blocks for the various measures is the number of enrollees for each plan. Although plans did not submit these data directly, this is a useful measure of each plan's size. As noted in Figure 1, enrollment varied both across plans and over time.

Figure 1: Enrollees over time



Users

When we compare the number of persons who received inpatient, outpatient, or physician/supplier Medicare services for a given plan, the result is the number of users per enrollee. For utilization purposes, this is a more stable indicator than claims per enrollee, since one or many claims may be submitted for a single encounter due to differences in contracting mechanisms. Since not all encounter types (e.g., inpatient, outpatient, physician/supplier) are present for all plans and all years, the figure reflects enrollment and utilization for calendar year 1998. Year-specific enrollment is defined as an enrollee who was enrolled in a given plan at any point during a year.

Across all encounter types, the experience of most plans seems to be similar to the national average. Only HAMP and Ohio Health Alliance (OHA) reported markedly fewer users than expected.

Figure 2: Users per 1000 enrollees

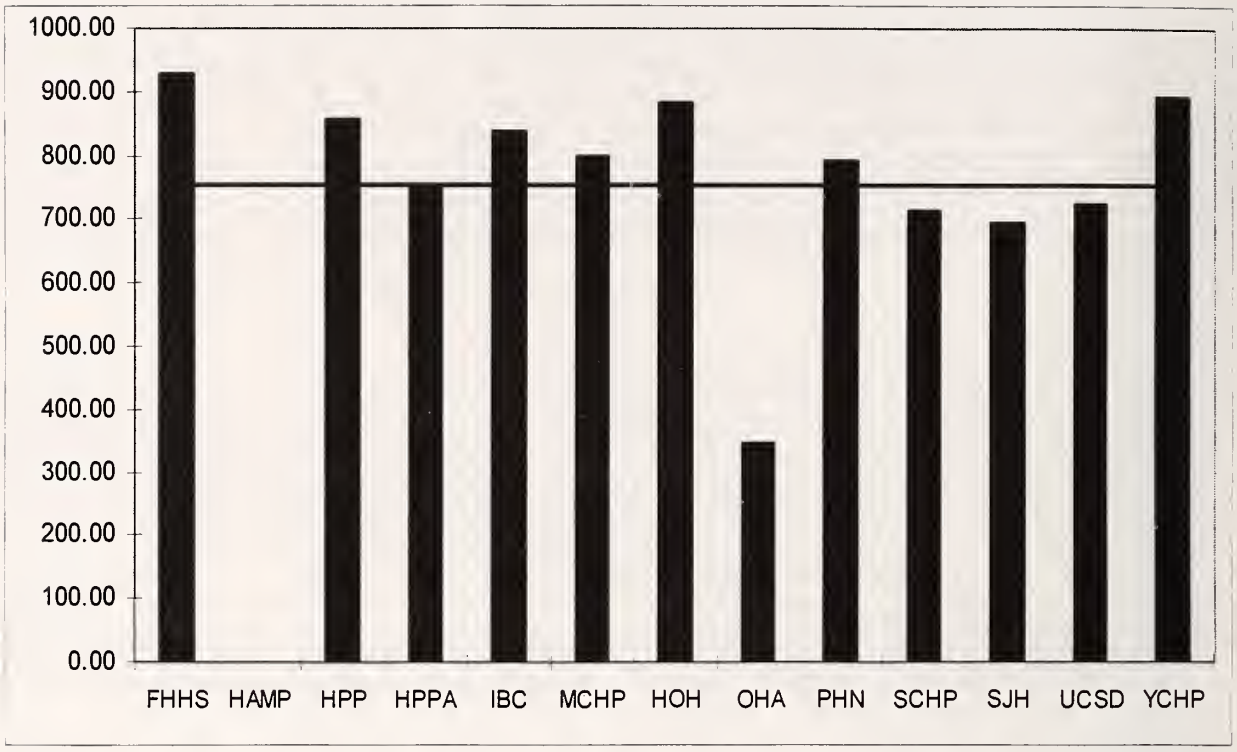
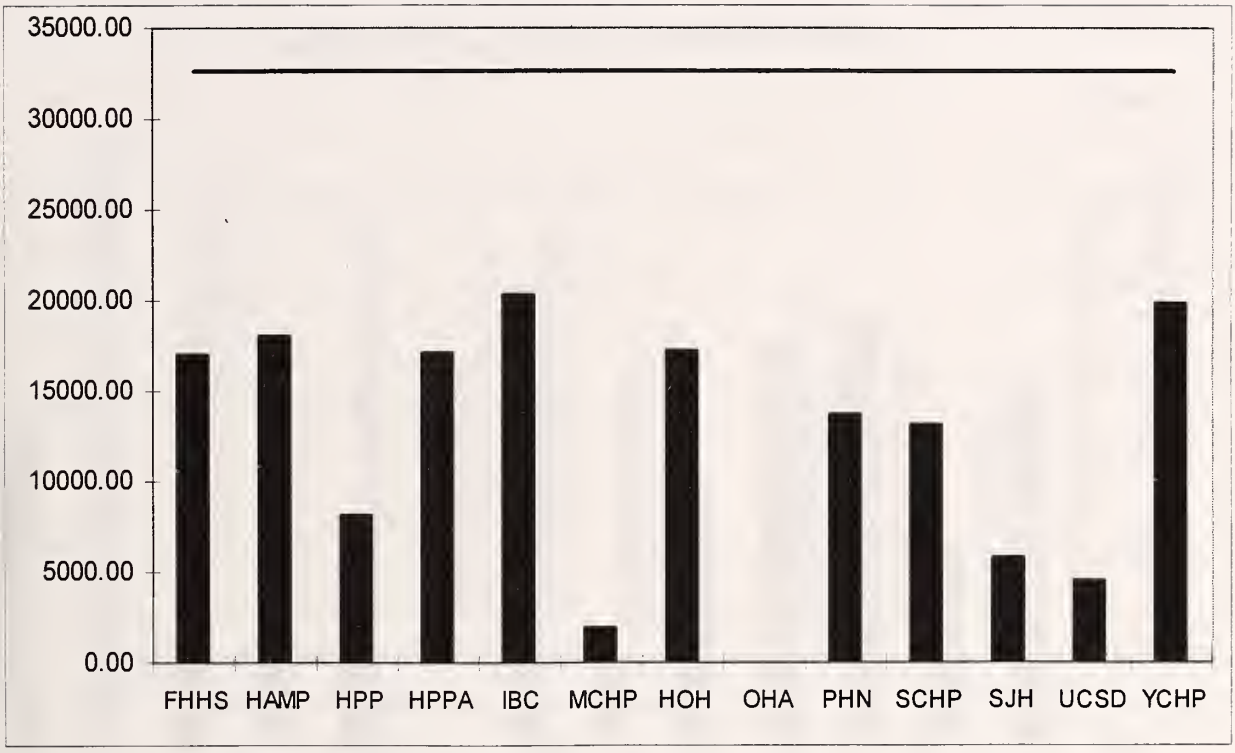


Figure 2 summarizes the number of persons served by each plan across all encounter types. Although informative, these analyses do not fully measure the completeness of data submitted since a user with ten claims is counted the same as a user with one claim. Thus, it is possible for a plan to have a ratio of users to enrollees that is approximately what one would expect, yet submit fewer than the expected claims.

In order to estimate the total number of claims in a manner compatible with the available benchmarks, we constructed a measure by adding the number of inpatient claims, outpatient claims, and Part B HCPCS codes. Although somewhat inelegant in that it combines high-level claims with more detailed codes, this maintains consistency with external benchmarks and avoids issues associated with bundling related services on a single claim as opposed to submitting several bills with one service each.

Figure 3 illustrates the total number of services for each plan relative to the national Medicare benchmark. Examination of these data, combined with information regarding each plan's submission effort, indicates that plans submitted fewer claim and service records than would be expected. For example, the total number of services for Mount Carmel Health Plan (MCHP) is very low because the plan did not submit any outpatient claims due to missing data needed to process the claim through the fee-for-service system.

Figure 3: Services 1000 enrollees



Analysis of specific claim types (e.g., inpatient, outpatient) indicates further variance between plans and over time.

Inpatient measures

Although inpatient discharges are not the most frequently provided service, they do represent the most intensive and expensive care provided. Inpatient services are also provided in a well-controlled organizational setting, and specific services are recorded in structured format using a well-defined set of rules and taxonomies. As such, inpatient data is often the most reliable and accurate data available. While some utilization differences between managed care and FFS populations can be expected, differences should generally be negligible considering the diverse nature of the plans.

Comparison to Benchmarks

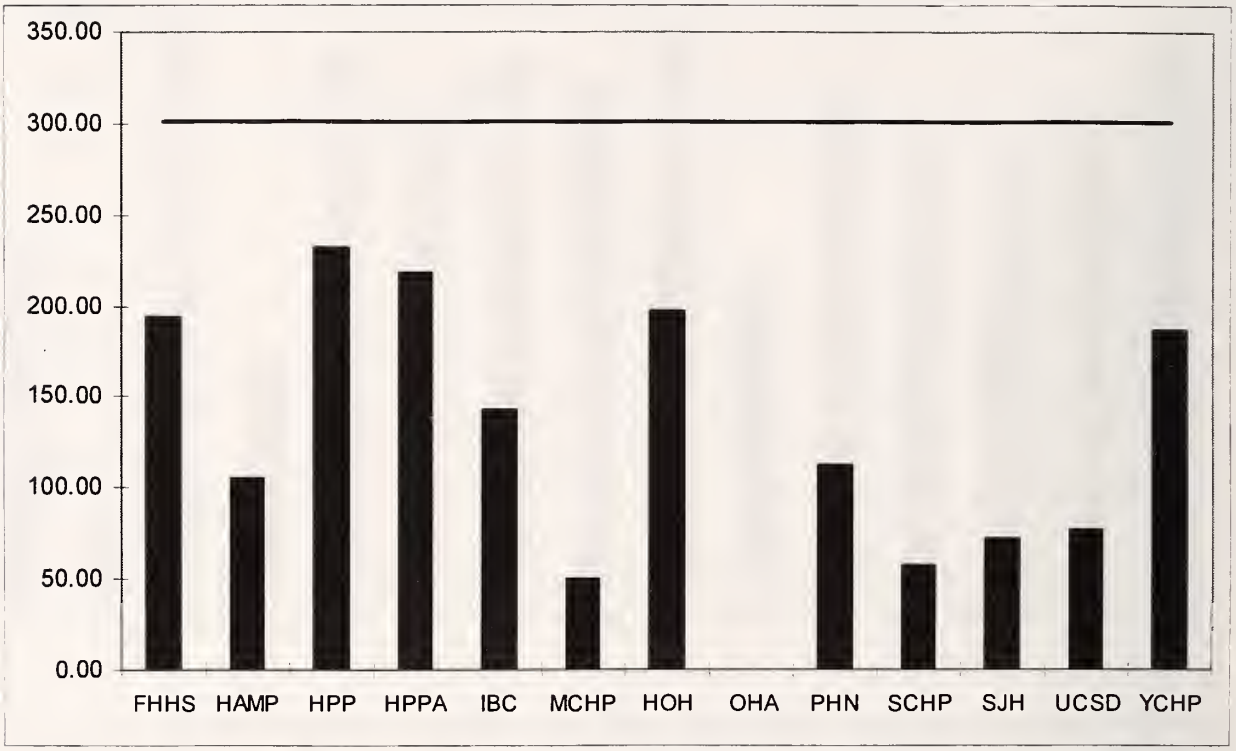
Discharges per 1000 enrollees

For data associated with services provided in 1998, all plans had fewer discharges per 1000 enrollees than would be expected based on national Medicare benchmarks. While some plans had zero discharges, others plans were considerably below the benchmark. For one plan, there was a five-fold difference between the discharges per 1000 enrollees and the benchmark. This is consistent with our understanding that most plans submitted incomplete inpatient information for 1998.

It would not be unexpected to see numbers that were slightly below the fee-for-service benchmark for some plans, given that it is possible that managed care plans are managing enrollees better than would be expected under FFS, and are thus able to reduce the number of enrollees who are admitted for inpatient

care. However, the more probable explanation, in most cases, is that data submission procedures and information technology issues prevented plans from submitting all of their inpatient encounter data.

Figure 4: Inpatient discharges per 1000 enrollees



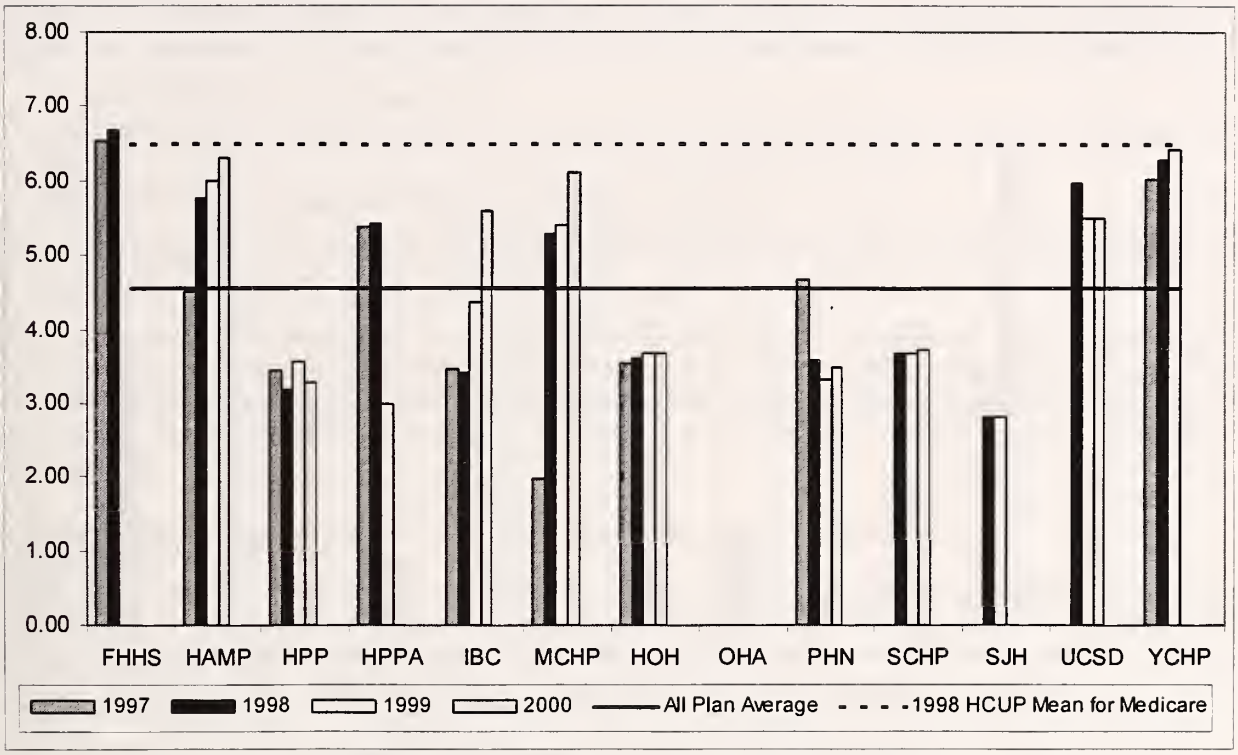
Number of Coded Diagnoses per Discharge

Whereas number of discharges is a measure of data completeness, number of coded diagnoses is a measure of data quality. Although some enrollees are more ill than others (and thus would have more diagnoses listed), and some hospitals are more likely to treat "sicker" populations, one would expect the average number of diagnoses to be more or less equivalent when aggregated at the plan level.

For these analyses, we examined the average number of diagnoses per discharge by plan and year of service. Our external benchmark data are derived from the Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample (NIS) for data year 1998. This database, funded by AHRQ, is designed to be representative of inpatient discharges in the United States, and it is based on inpatient data from more than twenty States. Since these data include information for all payers, analyses were performed to calculate the average number of diagnoses for those patients for whom Medicare was the primary expected payer.

As an internal benchmark, we calculated the average number of diagnoses for all plans and all years (1997-2000). Assuming coding practices and health status of enrollees are more or less equivalent across plans, comparison of each plan's average to this norm indicates which plans were more successful at submitting accurate discharge records.

Figure 5: Average number of coded diagnoses per inpatient discharge

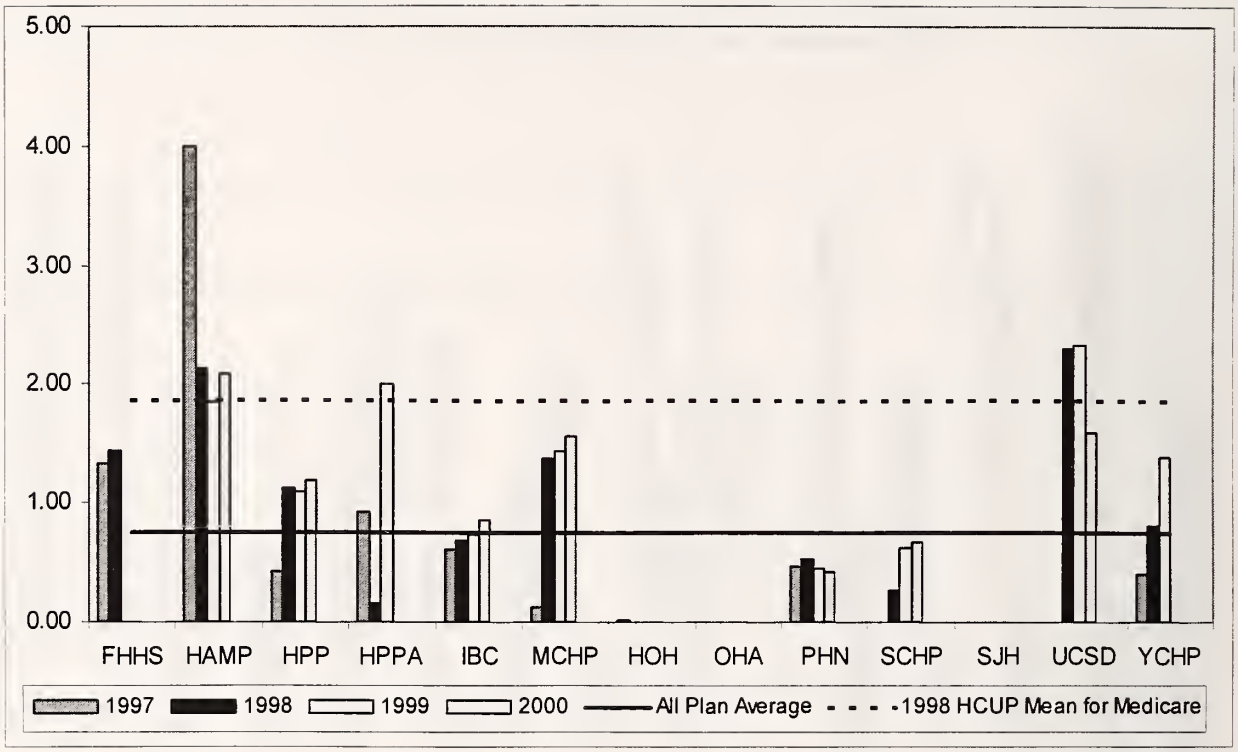


Examination of these data indicates that the majority of plans had fewer diagnoses per discharge than expected when compared to the HCUP NIS benchmark. Moreover, many of the plans had fewer diagnoses per discharge when compared to the all-plan norm. Finally, a comparison of the year-to-year changes within a plan suggests that for most plans data quality improved over time. Only two plans (HPPA and PHN) had a lower average number of diagnoses per discharges in their final data year than when they started. Most plans trended toward the HCUP average, including the two plans (FHHS and YCHP) with the highest average number of diagnoses per discharges. This suggests that data quality improved over time as plans became familiar with the data submission requirements and/or modified their information systems.

Number of Coded Procedures per Discharge

Just as average number of diagnoses can be used as a measure of data quality, average number of procedures can be used to measure the extent to which plans are submitting complete information as to the number of procedures performed. Whereas all inpatient admissions require a diagnosis code, not all records require a procedure code. As with diagnoses, one would expect to find person-to-person variation in the number of procedures performed during an inpatient stay, but we would expect the average for any given plan to be generally similar from one plan to the next. External benchmarks were derived from HCUP NIS data, and an average for all plans across all years was also calculated.

Figure 6: Average Number of Coded Procedures per Inpatient Discharge



Inspection of the average number of procedures show marked variation both across plans and within plans over time. Most plans reported far fewer procedures per discharge than would be expected based on the HCUP NIS benchmark, and many were below norm for all plans and all years. Of the plans with inpatient data, only HAMP consistently had an average number of procedures that approximated the external benchmark. FHHS and UCSD were also near the mean for each of the years they submitted data and above the all plans mean for all year. Average procedures per discharge increased over time for five other plans, which suggests their data quality improved as well. At the same time, some plans (e.g., HPPA, UCSD) exhibited somewhat unusual patterns when year-to-year averages were examined.

Summary of Inpatient Analyses

Taken together, these results suggest that plans had, at best, mixed success in submitting inpatient data through FFS channels. Most submitted what appears to be incomplete data in terms of both number of records and also the level of detail available on these records. Some of this difference may be attributed to utilization patterns in the FFS population when compared to the managed care population. However, these potential population differences are not supported by the variation between plans and within plans over time. Based on our discussions with plans, most plans reported that their inpatient data do not accurately reflect all of the inpatient services provided to their members due to difficulties in submitting complete data.

Outpatient Measures

Outpatient data submitted to CMS consists of institutional outpatient encounters, and almost exclusively encounters billed through a hospital's outpatient department. Although this includes a broad range of activities, outpatient encounters typically consist of same day surgeries and invasive diagnostic procedures. Unlike inpatient encounters, there is considerable variability between organizations in terms

how specific procedures are aggregated. In some cases, health care professionals with different organizational affiliations render services during an outpatient encounter. In other cases, individuals from the same organization render the same services. This can result in the following scenarios for one hypothetical "encounter" with (say) three services (e.g., lab test, radiology services, and anesthesia):

- a single header record three line items;
- two header records, one of which has two line items whereas the other header record has one line item;
- three header records, each of which include only one line item.

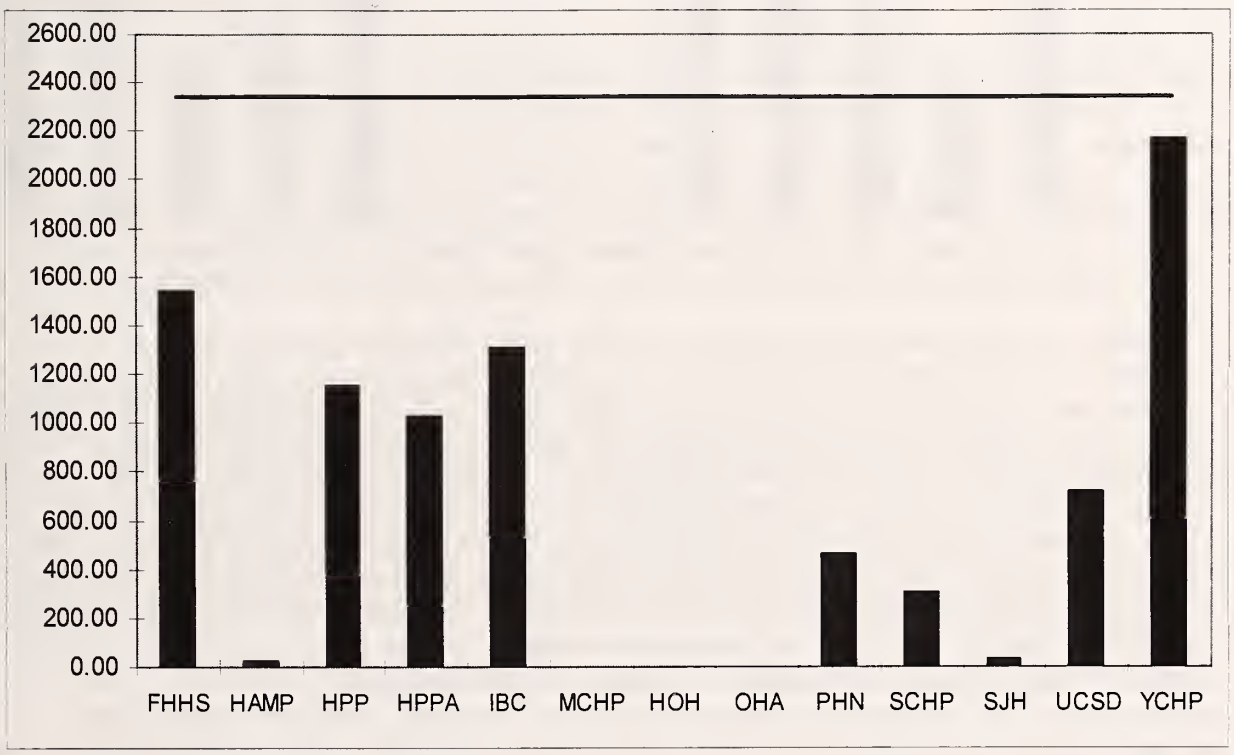
Each of the scenarios are considered valid, and the appropriateness of a given submission pattern depends on how a plan or facility contracts various services.

Due to data submission requirements, data availability issues, and other operational issues, a total of five plans were not able to successfully submit outpatient data. Our communications with CMS and plans also indicated that of those plans that were able to submit records, we could expect only partial submissions in some cases. Moreover, there is a paucity of relevant data that can be used to construct external benchmarks.

Claims per 1000 Enrollees

As with inpatient data, one of most basic measures of completeness is the number of claims (or bills) per 1000 enrollees. Although this measure is subject to variation due to contractual arrangements, this provides an approximation of the number of outpatient encounters for each plan. Since data are available for most plans for 1998, our analyses focused on data and benchmarks for 1998.

Figure 7: Outpatient Claims per 1000 Enrollees

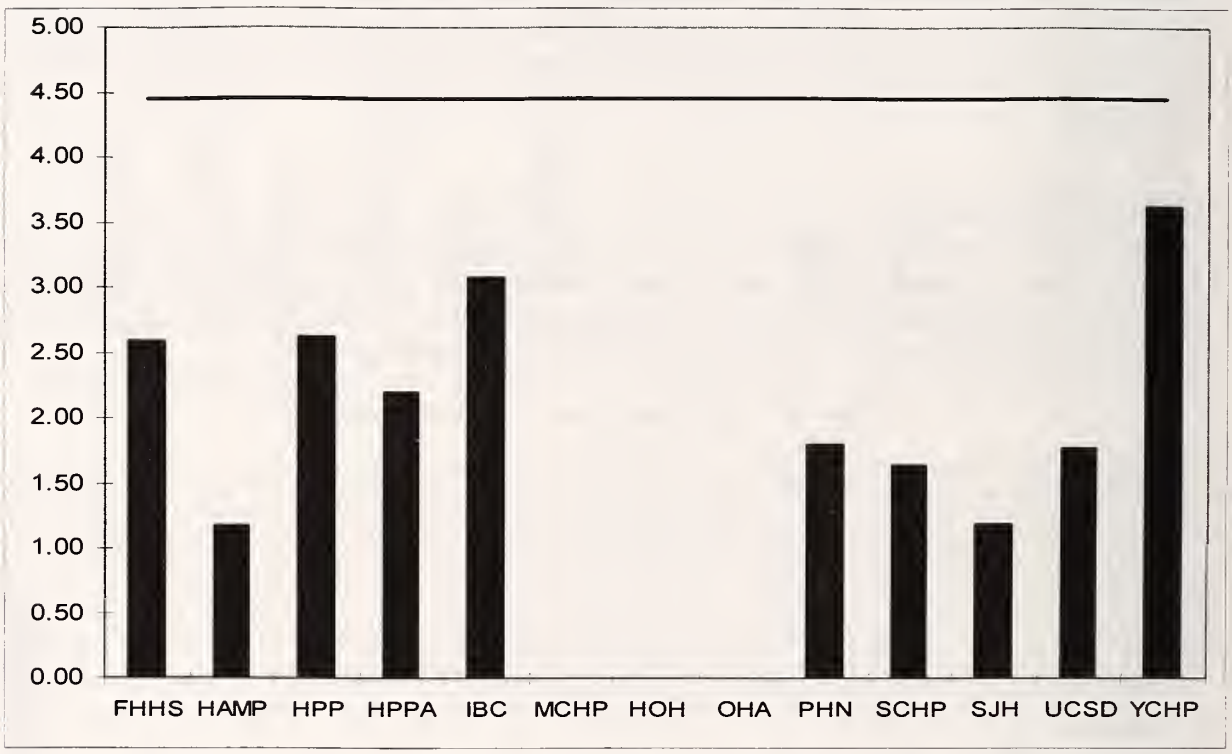


These data would typically indicate, that compared to the norm, most plans provide relatively few outpatient services to their enrollees, with the notable exception being YCHP. However, these results are more likely an indication of underreporting of outpatient pseudoclaims data.

Claims per User

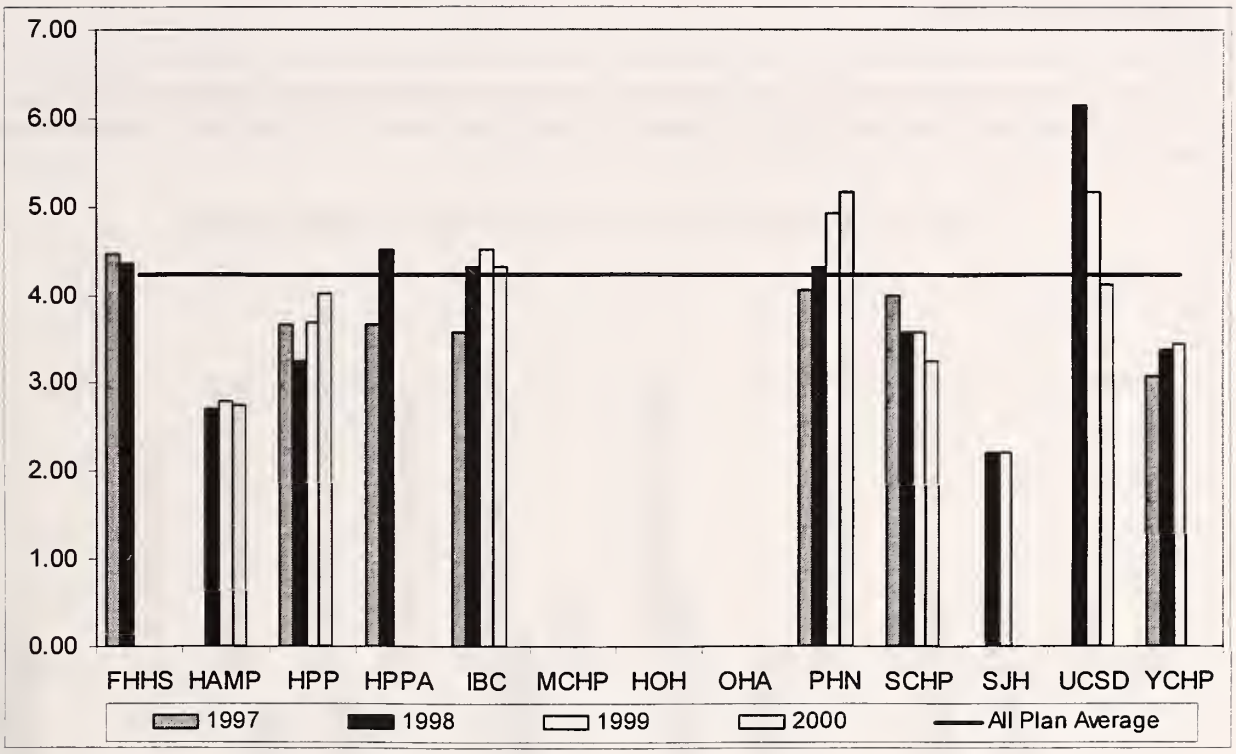
One of the next logical areas to address is the number of claims per outpatient user. This measure begins with a subset of users who received outpatient services, and it tabulates the number of outpatient encounters associated with each enrollee and plan. As with the previous analysis, data availability issues limited our examination to data encounters with service date 1998.

Figure 8: Average Number of Outpatient Claims per User



Consistent with the results associated with claims per 1000 enrollees, the number of claims per user was relatively low. This could indicate that plans were providing relatively few services to their enrollees and also that each enrollee who received services may have been receiving relatively few services. However, in providing technical assistance to the plans, we know that many plans had significant difficulty submitting outpatient claims through the fee-for-service submission channel. Relative to inpatient claims, outpatient claims are subject to an extensive number of edits that caused many claims to reject. Most plans were unable to correct and resubmit these claims, thus, the total claims available in the NCHF do not accurately reflect the total number of services provided. A natural follow up to this analysis is to examine the average number of line items and/or procedures for outpatient encounters. Although the raw data exist to calculate these measures, accurate benchmarks could not be obtained. Figure 9 illustrates the average number of line items per outpatient claim for each plan and year.

Figure 9: Average Number of Line Items per Outpatient Claim



Summary of Outpatient Analyses

These findings present a somewhat consistent set of results for outpatient data. Even though results indicate the number of claims per *enrollee* is relatively high for some plans, the rate of services is below the norm. Similarly, the number of claims per *user* is below the norm for the same data year. These findings point either to under utilization or incomplete data, and are more likely a sign that the data that successfully posted to the NCHF do not reflect the complete experience of enrollees. In fact, because outpatient claims are rejected at the claims level and not the line item, claims that were accepted into the NCHF should accurately list all line items from the original encounter. The total number of claims per user is low because entire claims are missing from the NCHF rather than having line items missing from individual claims.

Physician/Supplier (Part B) Measures

These data consist of physician services and office encounters. In many cases, these services are provided in an outpatient or office setting, although the data can also include professional services rendered in an inpatient or emergency department setting. In many managed care models, the plans themselves have little administrative control over the physician office encounter submission process. Moreover, there is typically a relatively high volume of Part B encounters associated with a given population. As such, many of these encounters have data entry or coding errors that add to the sometimes onerous data submission burden.

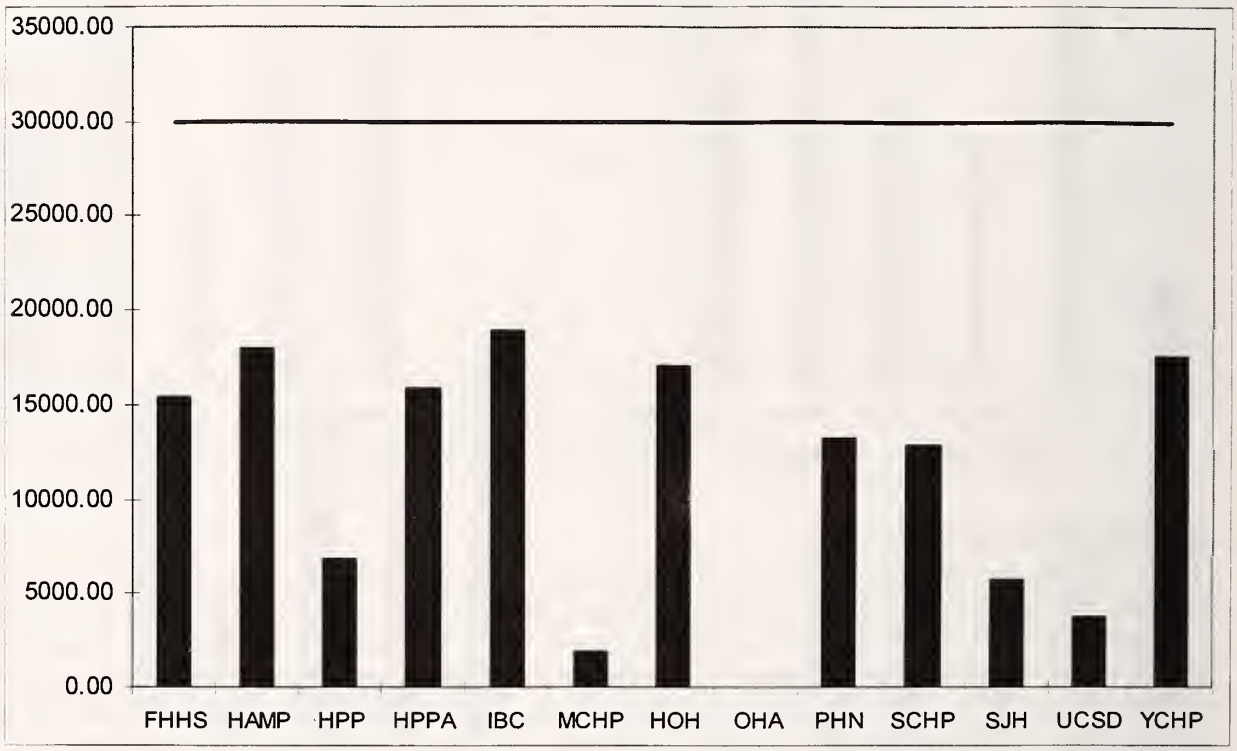
As with other encounter types discussed thus far, interactions with CMS and plans suggest that data may be incomplete. As with outpatient data, there are few relevant external benchmarks that can be applied to measure completeness. However, benchmarks are available for the number of services per enrollee and per user.

Comparison to Benchmarks

Services per 1000 Enrollees

In order to measure the number of services per 1000 enrollees, we used the number of CPT codes per enrollee. Since the number of CPT codes is always equal to or greater than the number of line items, this is a less conservative measure than the number of line items. Use of CPT codes also helps disentangle potential issues associated with billing related services separately.

Figure 10: Average Number of Part B Services per 1000 Enrollees

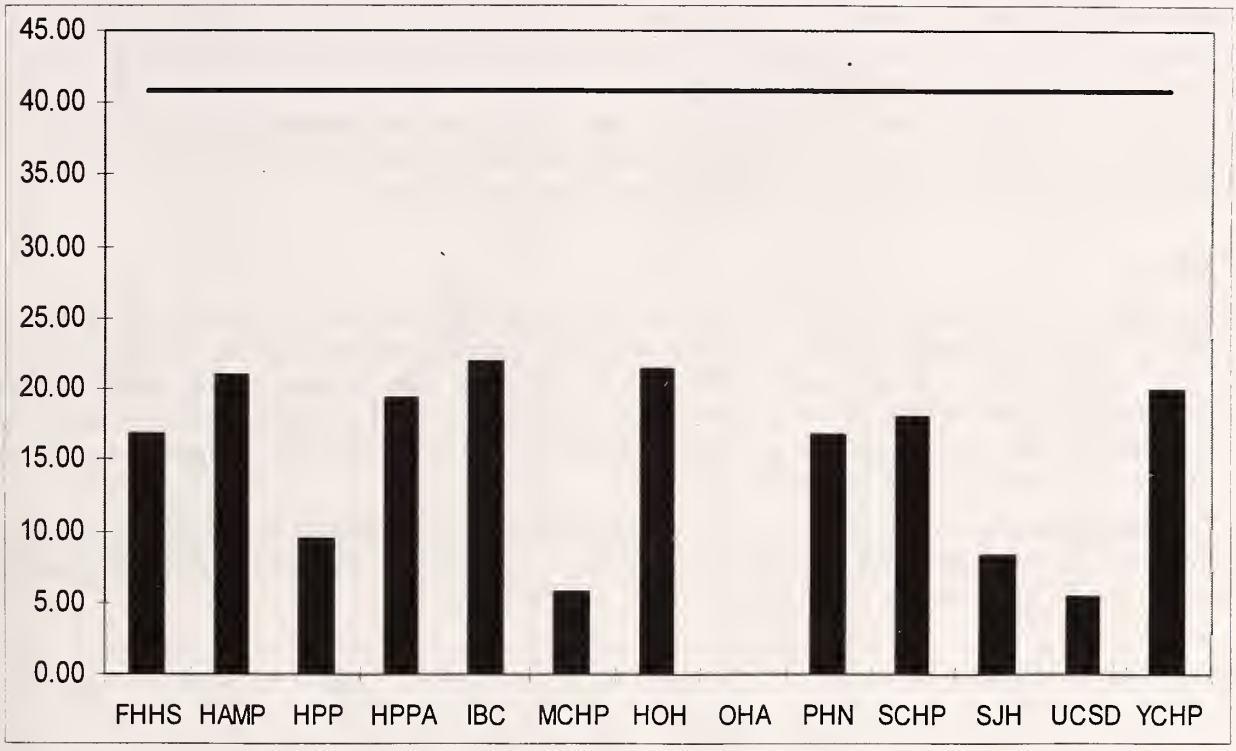


These data indicate that the demonstration plans submitted fewer services for data year 1998 than one would expect based on the national FFS norm. Some plans submitted relatively few (or no) Part B encounters, whereas others submitted approximately half the expected number of services per enrollee. Again, this is consistent with information received from plans and from our overall impression of Part B completeness. Medicare Choices Demonstration data are being underreported relative to the plans' actual professional service utilization.

Services per User

Examining the number of users who received services can also help shed light on the completeness of Part B data for demonstration plans. As with the enrollee-based analyses, there was some variance between plans, but, at best, plans were able to submit approximately half the expected number of Part B encounters.

Figure 11: Average Number of Part B Services per User



Summary of Physician/Supplier Analyses

Both sets of analyses suggest that enrollees were either under-served or that plans did not submit complete Part B data. While there is a fairly consistent pattern of differences between plans, the plans that appear to have the most complete utilization data are well below the benchmark. Based on our interactions with individual plans and CMS, we believe that the pattern of results obtained reflects incomplete submissions by the plans. Accordingly, these data should be used cautiously (if at all) for utilization analyses, epidemiological studies, and other investigations.

Summary of Aggregate Data

Taken together, the analyses of aggregate data suggest that data collection limitations, data submission procedures, and information technology limitations prevented plans from successfully submitting full and complete data for the three most prevalent (inpatient, outpatient, physician/supplier) encounter types. Although the benchmark data are based on Medicare FFS claims and enrollees, and one might expect differences between FFS and managed care populations, there are few viable explanations for the consistent differences across and between plans.

IV. COMPARISON OF MEDICAL RECORD DATA AND PLAN DATA

Methods

Our goal in validating records focuses on three basic classes of errors: missing data, surplus data, and erroneous data. Missing data are hospitalizations, office visits, and outpatient procedures that actually occurred (as documented in the medical record), but they are not represented in the electronic record. Conversely, surplus data are electronic records for which there are no corresponding medical records.

Finally, erroneous data are electronic records with one or more data elements that differ when compared to the medical record.

In order to measure the validity of encounter data, electronic records were compared to data in the medical record for selected enrollees. Since health plans typically submit large numbers of encounters, and have relatively large numbers of enrollees, it was not practical to validate data for all enrollees or encounters, especially on an on-going basis. In order to verify encounter data in the most efficient way possible, we selected samples of enrollees for each plan, quarter, and type of data (inpatient, outpatient, and physician office) where data were judged to be relatively complete.

Samples

Samples were drawn and medical records were requested from a total of seven plans. Characteristics of each sample are outlined in Table 1. Although the initial sampling design called for samples to be based on a sampling period of one quarter, this was modified for some samples since completeness and enrollment appeared to vary from one quarter to the next. Moreover, completeness and availability issues prevented us from drawing samples in a systematic manner that would allow for comparisons of accuracy over time, by plan, or across encounter type.

Each sample included a mix of enrollees for whom encounters were expected, as well as a set of enrollees for whom no encounters were expected. Requests for medical records were sent to each plan, and plans were asked to return records within 90 days.

Table 1: Summary of Sample Characteristics

UCSD

Sampling Period	Inpatient				Outpatient			
	Population	Expected		Total sample	Population	Expected		Total sample
		Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims			Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims	
1/1/1999 – 9/30/1999	227	41	20	61	0	0	0	0
7/1/1998 – 9/30/1999	0	0	0	0	1,189	23	20	43

FHHS

Sampling Period	Inpatient				Outpatient			
	Population	Expected		Total sample	Population	Expected		Total sample
		Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims			Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims	
10/1/1997 – 12/31/1997	649	72	20	92	3,416	76	0	76

YCHP

Sampling Period	Inpatient				Outpatient				Physician			
	Population	Expected		Total sample	Population	Expected		Total sample	Population	Expected		Total sample
		Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims			Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims			Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims	
1/1/1998 – 3/31/1998	56	26	19	45	255	38	20	58	729	19	20	39

MCHP

Sampling Period	Physician			
	Population	Expected		Total sample
		Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims	
1/1/1998 – 6/30/1998	1,906	28	19	47

HPP

Sampling Period	Outpatient				Physician			
	Population	Expected		Total sample	Population	Expected		Total sample
		Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims			Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims	
1/1/1998 – 6/30/1998	524	51	20	71	1,290	15	20	35

HPPA

Sampling Period	Inpatient				Physician			
	Population	Expected		Total sample	Population	Expected		Total sample
		Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims			Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims	
1/1/1997 – 12/31/1997	0	0	0	0	1,420	7	19	26
1/1/1997 – 12/31/1997	199	42	20	62	0	0	0	0

HOH

Sampling Period	Inpatient			
	Population	Expected		Total sample
		Sampled enrollees with pseudoclaims	Sampled enrollees without pseudoclaims	
1/1/1998 – 12/31/1998	1,532	43	20	63

Undercoding

By comparing the electronic records to the medical records sent by the plan, it is possible to ascertain the relative accuracy of the pseudoclaim data that posted to the NCHF. Broadly stated, there are two possible classes of findings: undercoding and overcoding. Undercoding refers to a lack of detail on the electronic pseudoclaim vis-à-vis the paper medical record. A classic example of undercoding is the omission of a diagnosis on the electronic record even though the medical record supports such a diagnosis. By contrast, overcoding describes the inclusion of information in an electronic pseudoclaim that is not substantiated in the paper medical record.

Results of the medical records review are presented in the following tables. Each table describes the number of encounters validated and the percent with an error. Since not all errors have the same impact, three categories are presented in each table: no error, critical errors and non-critical errors. Critical errors are those (such as missing diagnosis) that might affect the payment and/or quality of care if the electronic records were sole source of clinical information. Non-critical errors are also important, but reflect coding issues such as sequencing of codes rather than missing codes.

Across all plans and encounter types, critical undercoding errors appear to be fairly prevalent, with wide variation between plans and encounter types. UCSD has the lowest rate of critical undercoding errors with 6.88 percent of all outpatient diagnoses having some type of critical error. At the other extreme, approximately one-third (32.88 percent) of Humana of Houston's (formerly Memorial Sisters of Charity) inpatient diagnoses have some type of critical error. It is worth noting that undercoding of inpatient encounters is consistent with the relatively low number of diagnoses per inpatient discharge as noted in Figure 5.

Table 2: Undercoding Fault Rates by Plan and Encounter Type

UCSD

Diagnosis Validation Code/Detail			Service Type				All validated encounters	
			Inpatient		Outpatient			
			Count	Percent	Count	Percent	Count	Percent
Total Diagnoses validated for undercoding			393	100	160	100	553	100
	A: No error		324	82.44	149	93.13	473	85.53
	Sub-total		324	82.44	149	93.13	473	85.53
Critical errors	A: No error	610: Other incorrect code	0	0	1	0.63	1	0.18
	C: Diagnosis documented in record but code not listed in pseudoclaim		48	12.21	6	3.75	54	9.76
	F: Code selection error	600: Coded sign or symptom	3	0.76	0	0	3	0.54
		609: Incorrect 4th/5th digit	3	0.76	0	0	3	0.54
		610: Other incorrect code	14	3.56	4	2.5	18	3.25
	Sub-total		68	**17.3**	11	**6.88**	79	**14.29**
Non-critical errors	E: Sequencing error	501: Sequenced as secondary, should be primary	1	0.25	0	0	1	0.18
	Sub-total		1	0.25	0	0	1	0.18

FHHS

Diagnosis Validation Code/Detail			Service Type				All validated encounters	
			Inpatient		Outpatient			
			Count	Percent	Count	Percent	Count	Percent
Total Diagnoses validated for undercoding			652	100	216	100	868	100
	A: No error		580	88.96	167	77.31	747	86.06
	Sub-total		580	88.96	167	77.31	747	86.06
Critical errors	C: Diagnosis documented in record but code not listed in pseudoclaim		42	6.44	45	20.83	87	10.02
	F: Code selection error	600: Coded sign or symptom	3	0.46	0	0	3	0.35
		609: Incorrect 4th/5th digit	2	0.31	0	0	2	0.23
		610: Other incorrect code	13	1.99	2	0.93	15	1.73
	Sub-total		60	**9.2**	47	**21.76**	107	**12.33**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	7	1.07	1	0.46	8	0.92
		501: Sequenced as secondary, should be primary	5	0.77	1	0.46	6	0.69
	Sub-total		12	1.84	2	0.93	14	1.61

YCHP

Diagnosis Validation Code/Detail			Service Type						All validated encounters	
			Inpatient		Outpatient		Physician			
			Count	Percent	Count	Percent	Count	Percent	Count	Percent
Total Diagnoses validated for undercoding			205	100	125	100	147	100	477	100
	A: No error		177	86.34	99	79.2	119	80.95	395	82.81
	Sub-total		177	86.34	99	79.2	119	80.95	395	82.81
Critical errors	C: Diagnosis documented in record but code not listed in pseudoclaim		18	8.78	19	15.2	18	12.24	55	11.53
	F: Code selection error	600: Coded sign or symptom	1	0.49	0	0	2	1.36	3	0.63
		610: Other incorrect code	0	0	1	0.8	0	0	1	0.21
	Sub-total		19	**9.27**	20	**16**	20	**13.61**	59	**12.37**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	7	3.41	4	3.2	1	0.68	12	2.52
		501: Sequenced as secondary, should be primary	2	0.98	2	1.6	7	4.76	11	2.31
	Sub-total		9	4.39	6	4.8	8	5.44	23	4.82

HPP

Diagnosis Validation Code/Detail			Service Type Physician		All validated encounters	
			Count	Percent	Count	Percent
Total Diagnoses validated for undercoding			71	100	71	100
	A: No error		53	74.65	53	74.65
	Sub-total		53	74.65	53	74.65
Critical errors	C: Diagnosis documented in record but code not listed in pseudoclaim		17	23.94	17	23.94
	Sub-total		17	**23.94**	17	**23.94**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	1	1.41	1	1.41
	Sub-total		1	1.41	1	1.41

HPPA

Diagnosis Validation Code/Detail			Service Type Physician		All validated encounters	
			Count	Percent	Count	Percent
Total Diagnoses validated for undercoding			70	100	70	100
	A: No error		57	81.43	57	81.43
	Sub-total		57	81.43	57	81.43
Critical errors	C: Diagnosis documented in record but code not listed in pseudoclaim		3	4.29	3	4.29
	F: Code selection error	610: Other incorrect code	4	5.71	4	5.71
	Sub-total		7	**10**	7	**10**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	1	1.43	1	1.43
		501: Sequenced as secondary, should be primary	5	7.14	5	7.14
	Sub-total		6	8.57	6	8.57

HOH

Diagnosis Validation Code/Detail			Service Type: Inpatient		All validated encounters	
			Count	Percent	Count	Percent
Total Diagnoses validated for undercoding			368	100	368	100
	A: No error		238	64.67	238	64.67
	Sub-total		238	64.67	238	64.67
Critical errors	C: Diagnosis documented in record but code not listed in pseudoclaim		107	29.08	107	29.08
		610: Other incorrect code	1	0.27	1	0.27
	F: Code selection error	600: Coded sign or symptom	1	0.27	1	0.27
		604: Coded preoperative instead of postoperative	2	0.54	2	0.54
		609: Incorrect 4th/5th digit	1	0.27	1	0.27
		610: Other incorrect code	9	2.45	9	2.45
	Sub-total		121	**32.88**	121	**32.88**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	3	0.82	3	0.82
		501: Sequenced as secondary, should be primary	5	1.36	5	1.36
	F: Code selection error	500: Sequenced as principal/primary, should be secondary	1	0.27	1	0.27
	Sub-total		9	2.45	9	2.45

Overcoding

For the overcoding analyses, diagnoses were classified using a similar no error/critical error/non-critical error scheme. Critical overcoding errors include submission of a diagnosis that is not substantiated in the paper medical record or recording diagnoses that occurred in the past (e.g., history of AMI) as if they occurred during the encounter in question. Analyses of the overcoding results are shown in Table 3.

Table 3: Overcoding Fault Rates by Plan and Encounter Type

UCSD

Diagnosis Validation Code/Detail			Service Type				All validated encounters	
			Inpatient		Outpatient			
			Count	Percent	Count	Percent	Count	Percent
Total Diagnoses validated for overcoding			393	100	160	100	553	100
	A: No error		326	82.95	63	39.38	389	70.34
	Sub-total		326	82.95	63	39.38	389	70.34
Critical errors	A: No error	610: Other incorrect code	0	0	1	0.63	1	0.18
	D: Code listed in pseudoclaim but diagnosis not substantiated in record	400: Diagnosis not substantiated	8	2.04	2	1.25	10	1.81
	F: Code selection error		0	0	1	0.63	1	0.18
		605: Coded conditions previously treated	0	0	2	1.25	2	0.36
		607: Code more specific condition than is documented	0	0	1	0.63	1	0.18
		609: Incorrect 4th/5th digit	3	0.76	0	0	3	0.54
		610: Other incorrect code	14	3.56	4	2.5	18	3.25
	Sub-total		25	**6.36**	11	**6.88**	36	**6.51**
Non-critical errors	D: Code listed in pseudoclaim but diagnosis not substantiated in record	401: Diagnosis not documented for laboratory/radiology services performed	0	0	21	13.13	21	3.8
	E: Sequencing error	501: Sequenced as secondary, should be primary	1	0.25	0	0	1	0.18
	F: Code selection error		41	10.43	65	40.63	106	19.17
	Sub-total		42	10.69	86	53.75	128	23.15

FHHS

Diagnosis Validation Code/Detail			Service Type				All validated encounters	
			Inpatient		Outpatient			
			Count	Percent	Count	Percent	Count	Percent
Total Diagnoses validated for overcoding			652	100	216	100	868	100
	A: No error		594	91.1	188	87.04	782	90.09
	Sub-total		594	91.1	188	87.04	782	90.09
Critical errors	D: Code listed in pseudoclaim but diagnosis not substantiated in record	400: Diagnosis not substantiated	11	1.69	22	10.19	33	3.8
	F: Code selection error	602: Coded diagnosis that is part of disease process	0	0	2	0.93	2	0.23
		605: Coded conditions previously treated	5	0.77	0	0	5	0.58
		607: Code more specific condition than is documented	15	2.3	0	0	15	1.73
		609: Incorrect 4th/5th digit	2	0.31	0	0	2	0.23
		610: Other incorrect code	13	1.99	2	0.93	15	1.73
	Sub-total		46	**7.06**	26	**12.04**	72	**8.29**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	7	1.07	1	0.46	8	0.92
		501: Sequenced as secondary, should be primary	5	0.77	1	0.46	6	0.69
	Sub-total		12	1.84	2	0.93	14	1.61

YCHP

Diagnosis Validation Code/Detail			Service Type						All validated encounters	
			Inpatient		Outpatient		Physician			
			Count	Percent	Count	Percent	Count	Percent	Count	Percent
Total Diagnoses validated for overcoding			205	100	125	100	147	100	477	100
	A: No error		184	89.76	78	62.4	114	77.55	376	78.83
	Sub-total		184	89.76	78	62.4	114	77.55	376	78.83
Critical errors	D: Code listed in pseudoclaim but diagnosis not substantiated in record	400: Diagnosis not substantiated	3	1.46	18	14.4	19	12.93	40	8.39
	F: Code selection error	601: Coded 'ruled-out', 'probable', or 'questionable' diagnoses'	0	0	1	0.8	0	0	1	0.21
		605: Coded conditions previously treated	2	0.98	1	0.8	1	0.68	4	0.84
		607: Code more specific condition than is documented	7	3.41	3	2.4	5	3.4	15	3.14
		610: Other incorrect code	0	0	1	0.8	0	0	1	0.21
	Sub-total		12	**5.85**	24	**19.2**	25	**17.01**	61	**12.79**
Non-critical errors	D: Code listed in pseudoclaim but diagnosis not substantiated in record	401: Diagnosis not documented for laboratory/radiology services performed	0	0	17	13.6	0	0	17	3.56
	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	7	3.41	4	3.2	1	0.68	12	2.52
		501: Sequenced as secondary, should be primary	2	0.98	2	1.6	7	4.76	11	2.31
	Sub-total		9	4.39	23	18.4	8	5.44	40	8.39

HPP

Diagnosis Validation Code/Detail			Service Type: Physician		All validated encounters	
			Count	Percent	Count	Percent
Total Diagnoses validated for overcoding			71	100	71	100
	A: No error		62	87.32	62	87.32
	Sub-total		62	87.32	62	87.32
Critical errors	D: Code listed in pseudoclaim but diagnosis not substantiated in record	400: Diagnosis not substantiated	2	2.82	2	2.82
	F: Code selection error	602: Coded diagnosis that is part of disease process	2	2.82	2	2.82
		607: Code more specific condition than is documented	4	5.63	4	5.63
	Sub-total		8	**11.27**	8	**11.27**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	1	1.41	1	1.41
	Sub-total		1	1.41	1	1.41

HPPA

Diagnosis Validation Code/Detail			Service Type: Physician		All validated encounters	
			Count	Percent	Count	Percent
Total Diagnoses validated for overcoding			70	100	70	100
	A: No error		32	45.71	32	45.71
	Sub-total		32	45.71	32	45.71
Critical errors	D: Code listed in pseudoclaim but diagnosis not substantiated in record	400: Diagnosis not substantiated	10	14.29	10	14.29
	F: Code selection error	607: Code more specific condition than is documented	12	17.14	12	17.14
		610: Other incorrect code	4	5.71	4	5.71
	Sub-total		26	**37.14**	26	**37.14**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	1	1.43	1	1.43
		501: Sequenced as secondary, should be primary	5	7.14	5	7.14
	F: Code selection error		6	8.57	6	8.57
	Sub-total		12	17.14	12	17.14

HOH

Diagnosis Validation Code/Detail			Service Type: Inpatient		All validated encounters	
			Count	Percent	Count	Percent
Total Diagnoses validated for overcoding			368	100	368	100
	A: No error		288	78.26	288	78.26
	Sub-total		288	78.26	288	78.26
Critical errors	C: Diagnosis documented in record but code not listed in pseudoclaim	610: Other incorrect code	1	0.27	1	0.27
	D: Code listed in pseudoclaim but diagnosis not substantiated in record	400: Diagnosis not substantiated	10	2.72	10	2.72
	F: Code selection error	400: Diagnosis not substantiated	1	0.27	1	0.27
		604: Coded preoperative instead of postoperative	2	0.54	2	0.54
		605: Coded conditions previously treated	1	0.27	1	0.27
		607: Code more specific condition than is documented	8	2.17	8	2.17
		609: Incorrect 4th/5th digit	1	0.27	1	0.27
		610: Other incorrect code	9	2.45	9	2.45
	Sub-total		33	**8.97**	33	**8.97**
Non-critical errors	E: Sequencing error	500: Sequenced as principal/primary, should be secondary	3	0.82	3	0.82
		501: Sequenced as secondary, should be primary	5	1.36	5	1.36
	F: Code selection error		38	10.33	38	10.33
		500: Sequenced as principal/primary, should be secondary	1	0.27	1	0.27
	Sub-total		47	12.77	47	12.77

Summary

As with the undercoding analyses, critical errors are not uncommon and vary in prevalence from plan to plan and encounter type to encounter type. UCSD had the lowest rate of critical overcoding errors, with 6.36 percent of all diagnoses overcoded in some manner. Approximately 37 percent of all Part B diagnoses for HPPA were overcoded in some way.

V. SUMMARY AND CONCLUSIONS

Taken together, these findings suggest that plans were not able to submit complete or accurate data for all encounter types for all years. We believe this is a function of the data submission requirements/process and the limitation of plans' information systems and operational resources. Technical assistance activities seem to correlate with improved completeness, although it is difficult to infer any association with changes in data accuracy or quality.

Completeness

When the NCHF Medicare Choices Demonstration data are compared to Medicare norms, there are pronounced differences in completeness between plans, encounter types, and over time. In general, inpatient data appear to be the most complete, although some plans seem to be more complete than others. While few benchmarks exist for other encounter types, it appears that institutional outpatient and physician/supplier data are far less complete than inpatient data for most plans. This finding is consistent with the plan's emphasis on submitting complete inpatient data because those data were used to calculate the risk adjustment payment for most plans. Although data completeness for some encounter types improved over time, this is difficult to measure since plans ceased participating at various points in time.

Accuracy

Although we were able to develop benchmarks for at least some aspects of data completeness, external benchmarks are not readily available for the medical record validation component of these analyses. Nevertheless, critical error rates always exceeded six percent, and approached 40 percent for some plans and encounter types. The range of critical error rates was similar for both undercoding and overcoding, which suggests that errors are not biased in any given direction.

As mentioned previously, data availability issues did not allow for systematic validation of data across plans, over time, and for various encounter types. However, critical error rates (both undercoding and overcoding) seemed to be the highest for physician/supplier data, and the lowest for inpatient data. There is no way to tell whether coding accuracy improved over time, since relatively few samples were drawn and each plan was sampled at only one point in time. Since the enrollees were selected at random, these results should be generalizable to the larger population of encounters, at least within each plan.

Summary

The Medicare Choices Demonstration Plans that participated in this demonstration faced a variety of data submission challenges and issues. Plans were ill equipped to capture all of the required data needed to submit their encounter data through a fee-for-service submission process. Given that managed care plans do not utilize the same systems or resources available to providers, it is not surprising that they had difficulty navigating the data submission requirements. Though Medstat was able to help plans improve their overall data completeness by providing considerable technical assistance, some submission problems could not be overcome before the demonstration ended. Overall, data submitted are partially complete and are of variable quality by plan. While these data provide a better picture of utilization than an absence of data, current and potential users of these data should use caution when drawing conclusions about the nature and types of encounters associated with enrollees in the Demonstration.

APPENDIX A: DATA SUBMISSION DISCUSSION GUIDE

Discussion Guide to Assess Gaps in Data Quality or Completeness with Medicare Choices Demonstration Plans

1) Plan Information:

   a) Name:

   b) Interview Participants:

   c) Interviewer(s):

   d) Date of Interview:

2) Did your providers submit encounter data using ONLY standard data submission forms (UB-92 or HCFA 1500)? If no, and you used proprietary forms, did this impact the data completeness needed for claim submission to HCFA? (please describe)

3) Have you performed any studies to determine the completeness of the encounter data that you received? If yes, what were your findings? (If no, does the plan estimate that there are any gaps in data completeness?)

4) Have you had problems obtaining diagnosis codes with all of the digits from the providers? If yes, how did you fix the problem?

5) Have you had problems obtaining procedure codes with all of the digits from the providers? If yes, how did you fix the problem?

6) Were there been any changes to your encounter data processing system after the Demonstration project began? If yes, were there problems in the transition that affected encounter data (e.g., data lost, additional data elements captured in new system, etc.)?

7) Did you have any difficulties adapting your processing system to accommodate the Encounter Data submissions to HCFA? If yes, did these problems affect the encounter data?

8) Did you encounter any problems during the data submission process to your fiscal intermediary or carrier?

9) Did these problems affect the encounter data?

10) Were any data lost? If so, please specify type of data that were lost and provide details for how this was resolved.

11) What were your most problematic errors? Were there any claims you did not correct and resubmit? Please provide examples.

12) Please explain the process of correcting and resubmitting claims that were rejected by the Medicare fiscal intermediary. How successful were you in working denied claims?

13) How were the data tracked?

14) Did you reconcile that data submitted were ultimately posted to the National Claims History File?

15) What services were you unable to report to CMS by submitting claims data through fee-for-service channel (e.g., SNF services without a 3-day qualifying stay, chiropractic claims, etc.)?

16) In what ways do you feel the data do not fully represent all of the services you provide?

17) Is there any other information you would like CMS researchers to know about your claims data when using it for research or risk adjustment purposes?

APPENDIX B:

REVIEW OF WORKAROUNDS APPLIED TO INPATIENT, OUTPATIENT, AND PROFESSIONAL SERVICES/ DME CLAIMS

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 1 – Provider name, address, and telephone number	#62 PRSTATE	VALID DATA ARE REQUIRED				
FL 2 – Untitled						
FL 3 – Patient control number	#83 PTNTCNTL	VALID DATA ARE REQUIRED				
FL 4 – Type of bill	#28 FAC_TYPE #29 TYPESRVC #30 FREQ_CD	No workaround used.	Used Medstat workaround: If valid type not submitted, calculated using other claim information. Corrections were made by Health Partners - Rev code=403 (Mammogram, then set bill-type to 141) Provider-ID=xx2xxxx from 13x to 721. Originally, Bill-Type was derived from Claim-Type.	No workaround used.	Used Medstat workaround: If valid type not captured on claim, calculate TOB using other claim info such as provider location, provider type, type of service, etc.	Used Medstat workaround: If valid type not captured on claim, calculate TOB using other claim info such as provider location, provider type, type of service, etc.
FL 5 – Federal tax number						
FL 6 – Statement covers period (from-through)	#11 FROM_DT #12 THRU_DT	No workaround used.	No workaround used; FROM / TO Dates accepted AS-IS. (Adjusted Covered Days)	Used Medstat workaround: default admit date and discharge date.	No workaround used.	No workaround used; if claim rolled across month, statement covers period was adjusted.
FL 7 – Covered days	#135 UTIL_DAY	Used Medstat algorithm.*	Used Medstat algorithm. *	Used Medstat algorithm. *	Used Medstat algorithm. *	Used Medstat algorithm. *
FL 8 – Non-covered days	#143 NUTILDAY	Used Medstat algorithm.*	Used Medstat algorithm. *	Used Medstat algorithm. *	Used Medstat algorithm. *	Used Medstat algorithm. *
FL 9 – Co-insurance days	#137 COIN_DAY	No workaround used; valid data available.	Used Medstat algorithm. *	No workaround used; defaulted "0".	Used Medstat algorithm. *	Left blank.
FL 10 – Lifetime reserve days	#142 LRD_USE	No workaround used; valid data available.	Used Medstat algorithm. *	No workaround used; defaulted "0".	Used Medstat algorithm. *	Left blank.
FL 11 – Untitled						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 12 – Patient name	#48 SURNAME #49 FRSTINIT #50 MDL_INIT	VALID DATA ARE REQUIRED				
FL 13 – Patient address	#43 BENE_ZIP					
FL 14 – Patient's birthdate	#46 BENE_DOB					
FL 15 – Patient's sex	#44 SEX					
FL 16 – Patient's marital status						
FL 17 – Admission date	#106 ADMSN_DT	No workaround used.	Used Medstat workaround: if not available, used statement From Date unless claim was not an initial bill. In most cases, valid data submitted.	No workaround used.	No workaround used.	Used from date on claim; manually corrected errors as needed.
FL 18 – Admission hour						
FL 19 – Type of admission (required on inpatient bills only)	#107 TYPE_ADM	No workaround used; valid data available.	Used Medstat default: Default value=9 (Information N/A)	No workaround used; pulled from claim.	Used Medstat workaround: Default value=9 (Information N/A)	Used Medstat workaround: Default value=9 (Information N/A)
FL 20 – Source of admission	#87 SRC_ADMS	No workaround used; valid data available.	No workaround used; 9 was used as default for all claims.	No workaround used; pulled from claim.	Used Medstat workaround: Default value=3 (HMO referral)	Used Medstat workaround: Default value=3 (HMO referral)
FL 21 – Discharge hour						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 22 – Patient status	#87 STUS_CD	Used Medstat default: patient status=1 (only when data are missing)	No workaround used; 1 was used only if DOC-Type was missing. If patient Status was missing it stayed missing. If the Patient-Status=99 then it was set to 1.	Used Medstat default: patient status=1 (only when data are missing)	No workaround used.	Used Medstat default: patient status=1. Caused some subsequent claims to reject requiring manual correction.
FL 23 – Medical record number	#84 MDCL_REC	No workaround used.	No workaround used; medical record number never supplied.	No workaround used.	Used Medstat workaround: default a different patient identifier; claim number PCN.	No workaround used.
FL 24-30 – Condition codes	#188 RLT_COND	Used Medstat default codes; however, C5 and 04 are not used as defaults, only 40. Also, submitted additional condition codes pulled from provider claims.	Used Medstat default codes if valid data were missing.	No workarounds used; worked with fiscal intermediary to identify appropriate condition codes if missing.	Used Medstat workaround: default condition codes 40 and C5 when the patient had a same day transfer to another facility before midnight on the day of admission. For other inpatient stays, use condition code 04 and C5.	Used Medstat default codes if valid data were missing.
FL 31 – Untitled FL 32-35 – Occurrence codes and dates FL 36 – Occurrence span codes and dates FL 37 – Internal control number/Document control number (ICN/DCN) FL 38 – Untitled						
FL 39-41 – Value codes and amounts	#197 VAL_CD #198 VAL_AMT	No workaround used; valid data pulled from claims.	Used Medstat default codes if valid data were missing.	Used Medstat workaround: possible to calculate from type of bill and revenue code information on claim.	Used Medstat default codes if valid data were missing.	No workaround used.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 42 – Revenue code	#200 REV_CNTR	Stripped the following revenue codes for non-covered services: 253, 256, 374, 540-549, 630, 636, 637, 990-999	Used Health Partners workaround: Rev-Code to Rev-Code 190 to 120, 191 to 121, 240 to 250 Rev-990 BillType=13 Then Rev=929 Rev-821 BillType=72 Then Rev=881 Rev-450 ProcCd=99070 Then Rev=270 Rev-971 to 975 Then (HCFA1500) Rev=978 to 986 Then (HCFA1500) ProcCD=66984 found Then Insert Rev-276	No workarounds used.	Some revenue codes stripped from claim prior to submitting; taken from claim.	No workarounds used; stripped all ancillary services from inpatient claims.
FL 43 – Revenue description						
FL 44 – HCPCS	#207 HCPCS_CD	Stripped HCPCS prior to submitting.	Data left AS-IS.	No workarounds used.	Data stripped from claim prior to submitting.	Data not available and not submitted. No workarounds used.
FL 45 – Service date						
FL 46 – Service units	#220 REV_UNIT	VALID DATA ARE REQUIRED				
FL 47 – Total charges	#91 TOT_CHG #233 REV_CHG					
FL 48 – Non-covered charges	#234 REV_NCVR	Used HAMP workaround: charge total of rev codes 010-099 and 220-999. Note: 022 and 100-219 appear on 50 record.	Used Medstat workaround: total all charges for revenue codes: 253, 256, 273, 96X, 97X, 98X, and 99X *Rev-96 through 99 Set as Non-Covered Rev-253, 256, 273 Set as Non-Covered	Used Medstat workaround: total all charges for revenue codes: 253, 256, 273, 96X, 97X, 98X and 99X.	No workaround used.	
FL 49 - Untitled						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 50 A, B, C – Payer name		Used Medstat workaround: FI processed MSP claims as though Medicare was primary.	Used Medstat workaround: Processed MSP claims as though Medicare was primary. Percent of MSP not known.	No workaround used; MSP submitted as though Medicare was primary	Used Medstat workaround: FI processed MSP claims as though Medicare was primary.	No workaround used; FI processed claims as though Medicare was primary in all cases.
FL 50 A, B, C – Payer code	#58 PRPAY_CD	No workaround used; valid data submitted. For MSP claims, FI manually processed as though Medicare was primary; however, was for <1% of population.	Used Medstat workaround: If Medicare was primary payer, default value=Z.	Used Medstat workaround: If Medicare was primary payer, default value=Z.	Used Medstat workaround: If Medicare was primary payer, default value=Z.	No workaround used; FI processed claims as though Medicare was primary in all cases.
FL 51 A, B, C – Provider number	#19 PROVIDER	VALID DATA ARE REQUIRED				
FL 52 – Release of information						
FL 53 – Assignment of benefits certification indicator						
FL 54 A, B, C – Prior payments						
FL 55 – Estimated amount due						
FL 56 – Untitled FL 57 – Untitled						
FL 58 – Insured's name		Used Medstat workaround: if Medicare was not primary, used valid Insured's Name.	Used Medstat workaround: Insured's Name was used if Medicare was not primary.	Used Medstat workaround: Insured's Name was used if Medicare was not primary	No workaround used.	No workaround used; FI processed claims as though Medicare was primary in all cases.
FL 59 – Patient's relationship to insured	#8 BIC	Used Medstat workaround: if Medicare was not primary, used value Patient Relationship to Insured.	Used Medstat workaround: if Medicare was not primary, used value Patient Relationship to Insured. Defaulted to "0"	Used Medstat workaround: if Medicare was not primary, used value Patient Relationship to Insured.	No workaround used.	No workaround used; FI processed claims as though Medicare was primary in all cases.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 60 – Cert/SSN/HIC/ ID number	#6 CAN #8 BIC	VALID DATA ARE REQUIRED				
FL 61 – Group name		Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	No workaround used.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	No workaround used; FI processed claims as though Medicare was primary in all cases.
FL 62 – Insurance group number		Used Medstat workaround: left blank if Medicare was primary; otherwise, used group number of member's primary insurance group or plan.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group number of member's primary insurance group or plan.	No workaround used.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	No workaround used; FI processed claims as though Medicare was primary in all cases.
FL 63 – Treatment authorization code	#82 AUTHRZTN	VALID DATA ARE REQUIRED				
FL 64 – Employment status code		No workaround used.	No workaround used; used zeroes.	No workaround used.	No workaround used.	Left blank.
FL 65 – Employer name (required if patient is employed)		Used Medstat workaround: left blank if patient was working aged and/or Medicare was secondary. If employer name is not available, default "Demonstration MSP."	No workaround used; left blank.	No workaround used.	No workaround used.	No workaround used; FI processed claims as though Medicare was primary in all cases.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 66 – Employer location		Used Medstat workaround: left blank if patient was working aged and/or Medicare was secondary. If employer location not available, default plan address.	No workaround used; left blank.	No workaround used.	No workaround used.	No workaround used; FI processed claims as though Medicare was primary in all cases.
FL 67 – Principal diagnosis code	#52 PDGNS_CD	No workaround used.	Used Medstat workaround: Defaulted primary discharge diagnosis.	No workaround used.	No workaround used; valid data.	Used Medstat workaround: Defaulted primary discharge diagnosis.
FL 68-75 Other diagnoses codes	#181 DGNS_CD	Submitted a maximum of 10 diagnoses.	Submitted 4 diagnoses.	Up to 9 diagnoses submitted.	Up to 9 diagnoses submitted.	Up to 9 diagnoses submitted.
FL 76 – Admitting diagnosis	#109 AD_DGNS	Used Medstat workaround: defaulted principal diagnosis.	No workaround used.	No workaround used.	No workaround used; valid data.	Defaulted principal diagnosis.
FL 77 – E-Code FL 78 – Untitled FL 79 – Procedure coding method						
FL 80 – Principal procedure code and date (required on inpatient claims with a 36X revenue code)	#184 PRCDR_CD #185 PRCDR_DT	No workarounds used.	Principal proc code available (AS-IS); principal procedure date used (defaulted From Date)	No workarounds used.	No workarounds used.	No workarounds used.
FL 81 – Other procedure codes and dates.	#184 PRCDR_CD #185 PRCDR_DT	No workarounds used.	Other proc codes submitted AS-IS; other proc date used (defaulted To Date).	No workarounds used.	No workarounds used.	No workarounds used.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 82 – Attending/ Referring physician ID	#64 AT_UPIN	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider didn't have a UPIN, assigned value = OTH000. Also used MD0000, AA0000, PA0000, CNS000, CNA000, CNM000, NP0000, CSW000, or PT0000 based on provider type.	No workaround used: Either used UPIN or left blank	Used Medstat workaround when valid data were missing: defaulted admitting physician or PCP's UPIN. If not available, assigned value=OTH000.	Used Medstat workaround when valid data were missing: defaulted admitting physician or PCP's UPIN. If not available, assigned value=OTH000.	Used Medstat workaround: defaulted admitting physician or PCP's UPIN. If not available, assigned value=OTH000.
FL 82 – Attending/ Referring physician name	#66 AT_SRNM #67 AT_GVNNM #68 AT_MDL	Used Medstat workaround: defaulted "Referring, Physician MD" if physician name was missing; however, physician name was generally available.	No workaround used; left blank.	Used Medstat workaround: defaulted "Referring, Physician MD" if missing.	Used Medstat workaround: defaulted "Referring, Physician MD" if missing.	Used Medstat workaround: defaulted "Referring, Physician MD" if missing.
FL 83 – Other physician ID (required if a hospital procedure is performed)	#69 OP_UPIN #74 OT_UPIN	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000.	No workaround used; used attending physician UPIN only if Bill-Type was 11* or 83*. If missing, left blank.	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000.	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000.	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Inpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 83 – Other physician name (required if a hospital procedure is performed)	#71 OP_SRNM #72 OP_GVN #73 OP_MDL #76 OT_SRNM #77 OT_GVN #78 OT_MDL	No workaround used; used name if available. If not available, no default was used.	No workaround used; left blank.	Used Medstat workaround: if principal proc code is billed, field is required. If physician name missing, default "Referring, Physician MD."	Used Medstat workaround: if principal proc code is billed, field is required. If physician name missing, default "Referring, Physician MD."	Used Medstat workaround: if principal proc code is billed, field is required. If physician name missing, default "Referring, Physician MD."
FL 84 – Remarks (used for DME billings by HHA)						
* - Refer to Medstat algorithm in Medicare Encounter Data Submission Guide.						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 1 – Provider name, address, and telephone number	VALID DATA ARE REQUIRED				
FL 2 – Untitled					
FL 3 – Patient control number	VALID DATA ARE REQUIRED				
FL 4 – Type of bill	No workaround used. The following IP or SNF bill types were not submitted: 115, 117, 118, 721, 831, 838, 332	Used Medstat workaround: If valid type not captured on claim, calculate TOB using provider location. Everything submitted.	Used Medstat workaround: If valid type not captured on claim, calculate TOB using other claim info such as provider location, provider type, type of service, etc.	Used Medstat workaround: Type of bill calculated using place of service and provider type.	No workarounds used.
FL 5 – Federal tax number					
FL 6 – Statement covers period (from-through)	No workaround used.	No workaround used.	Used Medstat workaround: default admit date and discharge date.	No workaround used.	No workarounds used.
FL 7 – Covered days	No workaround used.	No workaround used.	Used Medstat algorithm. *	Used Medstat algorithm. *	No workarounds used.
FL 8 – Non-covered days	No workaround used.	No workaround used.	No workaround used; always zero.	Used Medstat algorithm. *	No workarounds used.
FL 9 – Co-insurance days	No workaround used.	No workaround used.	No workaround used; from claim.	Used Medstat algorithm. *	No workarounds used.
FL 10 – Lifetime reserve days	No workaround used.	No workaround used.	No workaround used; from claim.	Used Medstat algorithm. *	No workarounds used.
FL 11 – Untitled					

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 12 – Patient name	VALID DATA ARE REQUIRED				
FL 13 – Patient address					
FL 14 – Patient's birthdate					
FL 15 – Patient's sex					
FL 16 – Patient's marital status	VALID DATA ARE REQUIRED				
FL 17 – Admission date	No workaround used.	No workaround used.	Used Medstat workaround: if not available, used statement From Date unless claim was not an initial bill. In most cases, valid data submitted.	Used Medstat workaround: Used statement from date since admission date was N/A.	No workarounds used.
FL 18 – Admission hour					
FL 19 – Type of admission (required on inpatient bills only)	Used Medstat workaround: Default value=9 (Information N/A) - All claims	Used Medstat workaround: Default value=9; however, also indicated that defaulted to "2".	Used Medstat default: Default value=9 (Information N/A)	Used Medstat default: Default value=9 (Information N/A)	No workarounds used.
FL 20 – Source of admission	No workaround used; 1 or 4 was used as default value.	Used Medstat workaround: Default value=3; however, also indicated that defaulted to "9".	Used Medstat default: Default value=3 (HMO referral)	Used Medstat default: Default value=3 (HMO referral)	No workarounds used.
FL 21 – Discharge hour					

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Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 22 – Patient status	No workaround used.	No workaround used.	No workaround used; data extracted.	Used Medstat default: patient status=1	No workarounds used.
FL 23 – Medical record number	Used Medstat workaround: Defaulted to different patient identifier.	Used Medstat workaround: Defaulted to PHN claim #.	No workaround used; data extracted.	Used St. Joseph's member number	No workarounds used.
FL 24-30 – Condition codes	Used Medstat workaround: default condition codes 40 and C5 when the patient had a same day transfer to another facility before midnight on the day of admission. For other inpatient stays, use condition code 04 and C5.	No workaround used: submitted additional condition codes pulled from provider claims; missing, no 40 or C5.	No workaround used; submitted additional condition codes pulled from provider claims. Pulled from claim info; defaulted spaces when not available.	Did not submit record 41.	No workaround used.
FL 31 – Untitled FL 32-35 – Occurrence codes and dates FL 36 – Occurrence span codes and dates FL 37 – Internal control number/Document control number (ICN/DCN) FL 38 – Untitled					
FL 39-41 – Value codes and amounts	No workaround used.	No workaround used; valid data used.	Used Medstat workaround: possible to calculate from type of bill and revenue code information on claim.	None submitted	No workarounds used.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 42 – Revenue code	No workaround used.	No workaround used; the following rev codes were stripped prior to submitting: 255, 49X, 500, 636, 76X, 77X, 97X, 98X	Used Medstat workaround: possible to calculate with a crosswalk based on HCPCS and TOB info.	Stripped the following revenue codes: 10, 99,160, 169, 170, 179, 190, 199, 636, 985	No workarounds used.
FL 43 – Revenue description					
FL 44 – HCPCS	No workarounds used.	Data stripped from claim prior to submitting	Submitted from claim data when available.	Stripped HCPCS prior to submitting.	No workarounds used.
FL 45 – Service date					
FL 46 – Service units	VALID DATA ARE REQUIRED				
FL 47 – Total charges					
FL 48 – Non-covered charges	Used Medstat workaround: total all charges for revenue codes: 253, 256, 273, 96X, 97X, 98X and 99X.	No workaround used; data not sent.	No workaround used; no values sent.	Used Medstat workaround: total all charges for revenue codes: 253, 256, 273, 96X, 97X, 98X, and 99X	No workarounds used.
FL 49 - Untitled					

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 50 A, B, C – Payer name	Used Medstat workaround: If Medicare was primary, defaulted "Medicare." If secondary, primary payer name was used. If unavailable, default "Demonstration MSP."	MSP claims not processed by FI (<1%).	Used Medstat workaround: If Medicare was primary, defaulted "Medicare." If secondary, primary payer name was used. If unavailable, default "Demonstration MSP."	BCBS of GA (FI) processed MSP claims as though Medicare was primary.	No MSP claims were submitted.
FL 50 A, B, C – Payer code	Used Medstat workaround: If Medicare was primary payer, default value=Z.	MSP claims not processed by FI.	Used Medstat workaround: If Medicare was primary payer, default value=Z.	BCBS of GA (FI) processed MSP claims as though Medicare was primary.	No MSP claims were submitted.
FL 51 A, B, C – Provider number	VALID DATA ARE REQUIRED				
FL 52 – Release of information					
FL 53 – Assignment of benefits certification indicator					
FL 54 A, B, C – Prior payments					
FL 55 – Estimated amount due					
FL 56 – Untitled					
FL 57 – Untitled					
FL 58 – Insured's name	Used Medstat workaround: Insured's Name was used if Medicare was not primary.	MSP claims not processed by FI.	Used Medstat workaround: Insured's Name was used if Medicare was not primary.	BCBS of GA (FI) processed MSP claims as though Medicare was primary.	No MSP claims were submitted.
FL 59 – Patient's relationship to insured	Used Medstat workaround: if Medicare was not primary, used value Patient Relationship to Insured.	MSP claims not processed by FI.	Used Medstat workaround: if Medicare was not primary, used value Patient Relationship to Insured.	Defaulted all claims to 01 (patient is insured)	No MSP claims were submitted.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 60 – Cert/SSN/HIC/ ID number	VALID DATA ARE REQUIRED				
FL 61 – Group name	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	MSP claims not processed by FI.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	BCBS of GA (FI) processed MSP claims as though Medicare was primary.	No MSP claims were submitted.
FL 62 – Insurance group number	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	MSP claims not processed by FI.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	BCBS of GA (FI) processed MSP claims as though Medicare was primary.	No MSP claims were submitted.
FL 63 – Treatment authorization code	VALID DATA ARE REQUIRED				
FL 64 – Employment status code	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. Otherwise, valid data are required .	MSP claims not processed by FI.	No workaround used; coded "9."	Default=09 (status unknown) for all claims.	No MSP claims were submitted.
FL 65 – Employer name (required if patient is employed)	Used Medstat workaround: left blank if patient was working aged and/or Medicare was secondary. If employer name is not available, default "Demonstration MSP."	MSP claims not processed by FI.	Used Medstat workaround: left blank if patient was working aged and/or Medicare was secondary. If employer name is not available, default "Demonstration MSP."	BCBS of GA (FI) processed MSP claims as though Medicare was primary.	No MSP claims were submitted.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Inpatient Submissions

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 66 – Employer location	Used Medstat workaround: left blank if patient was working aged and/or Medicare was secondary. If employer location not available, default plan address.	MSP claims not processed by FI.	Used Medstat workaround: left blank if patient was working aged and/or Medicare was secondary. If employer location not available, default plan address.	BCBS of GA (FI) processed MSP claims as though Medicare was primary.	No MSP claims were submitted.
FL 67 – Principal diagnosis code	No workaround used.	Used Medstat workaround: principal diagnosis from claim used.	Used Medstat workaround: Defaulted primary discharge diagnosis.	Used Medstat workaround: Defaulted primary discharge diagnosis.	No workarounds used.
FL 68-75 Other diagnoses codes	N/A	Amisys holds 10; Up to 9 diagnoses submitted.	Up to 9 diagnoses submitted.	Submitted a maximum of 3 diagnoses codes.	No workarounds used.
FL 76 – Admitting diagnosis	No workaround used.	No workaround used.	Used Medstat workaround: defaulted principal or diagnosis.	Used Medstat workaround: defaulted principal or discharge diagnosis.	No workarounds used.
FL 77 – E-Code FL 78 – Untitled FL 79 – Procedure coding method					
FL 80 – Principal procedure code and date (required on inpatient claims with a 36X revenue code)	No workarounds used.	No workarounds used.	No workarounds used; no dates sent.	Principal procedure code - procedures were stripped from claim prior to submitting. Principal procedure date - Principal procedure not submitted.	No workarounds used.
FL 81 – Other procedure codes and dates.	No workarounds used for other proc codes; admission date used for other proc date.	No workarounds used.	No workarounds used; no date sent.	Procedures stripped from claim prior to submitting. Other procedure dates not submitted.	No workarounds used.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 82 – Attending/ Referring physician ID	Used Medstat workaround when valid data were missing: defaulted admitting physician or PCP's UPIN. If not available, assigned value=OTH000.	Used Medstat workaround when valid data were missing: defaulted admitting physician or PCP's UPIN. If not available, assigned value=OTH000.	Used Medstat workaround when valid data were missing: defaulted admitting physician or PCP's UPIN. If not available, assigned value=OTH000.	Used Medstat workaround when valid data were missing: defaulted admitting physician or PCP's UPIN. If not available, assigned . value=OTH000.	Used Medstat workaround when valid data were missing: defaulted admitting physician or PCP's UPIN. If not available, assigned value=OTH000.
FL 82 – Attending/ Referring physician name	Used Medstat workaround: defaulted "Referring, Physician MD" if missing.	No workaround used.	Used Medstat workaround: defaulted "Referring, Physician MD" if missing.	Default="Attending physician"	Used Medstat workaround: Default="Referring, Physician MD"
FL 83 – Other physician ID (required if a hospital procedure is performed)	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000.	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000.	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000.	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000.	Used Medstat workaround: Default admitting physician or PCP's UPIN. If provider does not have UPIN, assign value=OTH000.

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Inpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 83 – Other physician name (required if a hospital procedure is performed)	Used Medstat workaround: if principal proc code is billed, field is required. If physician name missing, default "Referring, Physician MD."	No workaround used.	Used Medstat workaround: if principal proc code is billed, field is required. If physician name missing, default "Referring, Physician MD."	Default = "Other Physician"	Used Medstat workaround: Default="Referring, Physician MD"
FL 84 – Remarks (used for DME billings by HHA)					
* - Refer to Medstat algorithm in Medicare Encounter Data Submission Guide.					

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 1 – Provider name, address, and telephone number	#62 PRSTATE	VALID DATA ARE REQUIRED				
FL 2 – Untitled						
FL 3 – Patient control number	#83 PTNTCNTL	VALID DATA ARE REQUIRED				
FL 4 – Type of bill	#28 FAC_TYPE #29 TYPESRVE #30 FREQ_CD	No workaround used.	Used Medstat workaround: If valid type was unavailable, calculated bill type using other claim information.	No workaround used.	Used Medstat workaround: If valid type was unavailable, calculated bill type using other claim information.	N/A - Outpatient data not submitted.
FL 5 – Federal tax number						
FL 6 – Statement covers period (from-through)	#11 FROM_DT #12 THRU_DT	VALID DATA ARE REQUIRED				
FL 7 – Covered days FL 8 – Non-covered days FL 9 – Co-insurance days FL 10 – Lifetime reserve days FL 11 – Untitled						
FL 12 – Patient name	#11 SURNAME #49 FRSTINIT #50 MDL_INIT	VALID DATA ARE REQUIRED				
FL 13 – Patient address	# 43 BENE_ZIP					
FL 14 – Patient's birthdate	#46 BENE_DOB					
FL 15 – Patient's sex	#44 SEX					
FL 16 – Patient's marital status FL 17 – Admission date. FL 18 – Admission hour						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 19 – Type of admission (required on inpatient bills only)		No workaround used; valid data available.	Used Medstat workaround: Default value=9 (information not available)	No workaround used.	Used Medstat workaround: Default value=9 (information not available)	N/A - Outpatient data not submitted
FL 20 – Source of admission		No workaround used.	No workaround used; 9 was used as default.	No workaround used.	Used Medstat workaround: Default value=3 (HMO Referral)	N/A - Outpatient data not submitted
FL 21 – Discharge hour						
FL 22 – Patient status	#87 STUS_CD	Used Medstat workaround: patient status=1	Used Medstat workaround: Patient status=1.	Used Medstat workaround: Patient status=1.	Used Medstat workaround: Patient status=1.	N/A - Outpatient data not submitted
FL 23 – Medical record number	#84 MDCL_REC	Used Medstat workaround: okay to default a different patient identifier.	No workaround used; not supplied.	No workaround used.	Used Medstat workaround: okay to default a different patient identifier. Used patient control #.	N/A - Outpatient data not submitted
FL 24-30 – Condition codes	#147 RLT_COND	Condition codes were pulled from claims data.	Condition codes were pulled from claims data.	Condition codes pulled from claims data.	Default=C5	N/A - Outpatient data not submitted
FL 31 – Untitled						
FL 32-35 – Occurrence codes and dates	#149 OCRNC_CD #150 OCRNCDT	Occurrence codes pulled from claims data.	Occurrence codes pulled from claims data. If Rev-Code 42* was found on the service line then: Occur-Codes 11 and 35 was required.	Occurrence codes pulled from claims data.	Not submitted; errors occurred on therapy visits.	N/A - Outpatient data not submitted

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 36 – Occurrence span codes and dates	#152 SPAN_CD #153 SPANFROM #154 SPANTHRU	Span codes and dates pulled from claims data.	Span codes and dates pulled from claims data. If Span-Code=70 then Span-From-Date must precede From-Date. (Caused errors)	Span codes and dates pulled from claims data.	A few SNF claims went through.	N/A - Outpatient data not submitted
FL 37 – Internal control number/Document control number (ICN/DCN) FL 38 – Untitled						
FL 39-41 – Value codes and amounts	#156 VAL_CD #157 VAL_AMT	Value codes pulled from claims data.	Value codes pulled from claims data. **41** - Will be forced if RecTyp61 contains Rev-Code of 960. 962 - 964, 969 - 974, 976 - 979, 980 - 989 **50** - Will be forced if Rev-Code of 24* is found.	Value codes pulled from claims data.	Default=zeroes	N/A - Outpatient data not submitted

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 42 – Revenue code	#159 REV_CNTR	No workaround used; the following revenue codes were stripped prior to sending: 990-999.	Used Medstat workaround: Valid data submitted. If not, used following: Rev-Code to Rev-Code 190 to 120, 191 to 121, 240 to 250 Rev-990 BillType=13 Then Rev=929 Rev-821 BillType=72 Then Rev=881 Rev-450 ProcCd=99070 Then Rev=270 Rev-971 to 975 Then (HCFA1500) Rev=978 to 986 Then (HCFA1500) ProcCD=66984 found Then Insert Rev-276	No workaround used.	Some rev codes were stripped from claim prior to submitting. The following codes were stripped: 170, 229 & 240	N/A - Outpatient data not submitted
FL 43 – Revenue description						
FL 44 – HCPCS/Rates	#166 HCPCS_CD #180 REV_RATE	Missing claims were from Dec 97 - Feb 99.	Some claims were missing HCPCS and could not be submitted.	No workaround used.	No workarounds used	N/A - Outpatient data not submitted
FL 45 – Service Date	#201 REV_DT					
FL 46 – Service units	#179 REV_UNIT					

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 47 – Total charges	#91 TOT_CHRG #192 REV_CHG	VALID DATA ARE REQUIRED				
FL 48 – Non-covered charges	#193 REV_NCVR	No workaround used; defaulted to 0. Not required on OP claims.	Used Medstat workaround: Totaled all charges for revenue codes 253, 256, 273, 96X, 97X, 98X, 99X.	Used Medstat workaround: Totaled all charges for revenue codes 253, 256, 273, 96X, 97X, 98X, 99X.	No workaround used.	N/A - Outpatient data not submitted
FL 49 - Untitled						
FL 50 A, B, C – Payer name		Used Medstat workaround: If Medicare was primary payer, defaulted "Medicare." If Medicare was secondary, primary payer name was used.	No workarounds used.	Used Medstat workaround: If Medicare was primary payer, defaulted "Medicare." If Medicare was secondary, primary payer name was used.	Used Medstat workaround: If Medicare was primary payer, defaulted "Medicare." If Medicare was secondary, primary payer name was used.	N/A - Outpatient data not submitted
FL 50 A, B, C – Payer code	#58 PRPAY_CD	No workaround used; valid data available.	No workaround used; instead used XVMedicare.	Used Medstat workaround: If Medicare was primary payer, defaulted "Medicare." If Medicare was secondary, primary payer name was used.	Used Medstat workaround: If Medicare was primary payer, default value = Z. If not primary, used A for Working Aged.	N/A - Outpatient data not submitted
FL 51 A, B, C – Provider number	#19 PROVIDER	VALID DATA ARE REQUIRED				
FL 52 – Release of information		No workaround used; valid data available.	No workaround used; left spaces.	Used Medstat workaround: default value=N (no release on file).	Used Medstat workaround: default value=N (no release on file).	N/A - Outpatient data not submitted

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 53 – Assignment of benefits certification indicator						
FL 54 A, B, C – Prior payments.		No workaround used; non-covered amount used if reason was WC, CB, or LB.	Used Medstat workaround: Default value=zero fill.	Used Medstat workaround: Default value=zero fill.	Used Medstat workaround: Default value=zero fill.	N/A - Outpatient data not submitted
FL 55 – Estimated amount due FL 56 – Untitled FL 57 – Untitled						
FL 58 – Insured's name		Used Medstat workaround: If Medicare was not primary, used valid Insured's Name.	Used Medstat workaround: If Medicare was not primary, used valid Insured's Name.	No workaround used.	FI manually processed MSP claims as though Medicare were primary. Insured's Name=Patient's Name	N/A - Outpatient data not submitted
FL 59 – Patient's relationship to insured	#8 BIC	Used Medstat workaround: If Medicare was not primary, used value Patient Relationship to Insured.	No workaround used; defaulted to zeroes.	Worksheet left blank.	FI manually processed MSP claims as though Medicare were primary. Default=01.	N/A - Outpatient data not submitted
FL 60 – Cert/SSN/HIC/ ID number	#6 CAN #8 BIC	VALID DATA ARE REQUIRED				
FL 61 – Group name		Used Medstat workaround: left blank if Medicare was primary; otherwise, used group number of member's primary insurance group or plan.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group number of member's primary insurance group or plan.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group number of member's primary insurance group or plan.	Field left blank; Medicare was primary.	N/A - Outpatient data not submitted

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 62 – Insurance group number		Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	Field left blank; Medicare was primary.	N/A - Outpatient data not submitted
FL 63 – Treatment authorization code						
FL 64 – Employment status code		No workaround used.	No workaround used; defaulted to zeroes.	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. Otherwise, valid data required.	Field left blank.	N/A - Outpatient data not submitted
FL 65 – Employer name (required if patient is employed)		Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary.	No workaround used; left spaces.	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. If unavailable, default "Demonstration MSP."	Field left blank.	N/A - Outpatient data not submitted
FL 66 – Employer location		Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary.	No workaround used; left spaces.	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. If unavailable, default plan address.	Field left blank.	N/A - Outpatient data not submitted
FL 67 – Principal diagnosis code	#52 PDGNS_CD	VALID DATA ARE REQUIRED				
FL 68-75 Other diagnoses codes	#140 DGNS_CD	9 diagnosis codes submitted.	Submitted a maximum of 4 diagnoses codes.	No workaround used.	9 diagnosis codes submitted.	N/A - Outpatient data not submitted
FL 76 – Admitting diagnosis FL 77 – E-Code						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 78 – Untitled FL 79 – Procedure coding method						
FL 80 – Principal procedure code and date.	#143 PRCDR_CD #145 PRCDR_DT	No workaround used.	No workarounds used.	No workaround used.	No workarounds used.	N/A - Outpatient data not submitted
FL 81 – Other procedure codes and dates.						
FL 82 – Attending/Referring physician ID	#164 AT_UPIN	Used Medstat workaround: Defaulted admitting physician or PCP's UPIN. If provider did not have UPIN, assigned value=OTH000. Also used MD0000, AA0000, PA0000, CNS000, CNA000, CNM000, NP0000, CSW000, OR PT0000 based on provider type.	No workaround used; in most cases UPIN available. If not, then a UPIN was created based on Specialty code. But the surrogate UPIN was a 999xx number.	Used Medstat workaround: default admitting physician or PCP's UPIN. If unavailable, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's UPIN. If unavailable, assign value=OTH000.	N/A - Outpatient data not submitted
FL 82 – Attending/Referring physician name	#66 AT_SRNM #67 AT_GVNNM #68 AT_MDL	Used Medstat workaround: defaulted "Referring, Physician MD" if physician name was missing; however, name was generally used.	Used Medstat workaround: defaulted "Referring, Physician MD" if physician name was missing.	Used Medstat workaround: defaulted "Referring, Physician MD" if physician name was missing.	Used Medstat workaround: defaulted "Referring, Physician MD" if physician name was missing. Also indicated that default=Physician Attending	N/A - Outpatient data not submitted

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

UB-92 Data Element - Outpatient	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 83 – Other physician ID and name (required if an ambulatory HCPCS code is submitted)	#69 OP_UPIN #74 OT_UPIN	Used Medstat workaround: default admitting physician or PCP's name and UPIN. If provider does not have a UPIN, assign value=OTH000.	No workaround used; if bill type was 11* or 83* then use admitting or PCP Name and UPIN. If UPIN is not assigned then use the 9999xx number.	Used Medstat workaround: default admitting physician or PCP's name and UPIN. If provider does not have a UPIN, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's name and UPIN. If provider does not have a UPIN, assign value=OTH000.	N/A - Outpatient data not submitted
FL 83 – Other physician name (required if an ambulatory HCPCS code is submitted)	#71 OP_SRNM #72 OP_GVN #73 OP_MDL #76 OT_SRNM #77 OT_GVN #78 OT_MDL	No workaround used; used name if available. If not, no default used.	No workaround used; if bill type was 11* or 83* then use admitting or PCP Name and UPIN. If UPIN is not assigned then use the 9999xx number.	Used Medstat workaround: If a principal proc code was billed, this field was required. If physician name missing, default "Referring, Physician MD."	Used Medstat workaround: If a principal proc code was billed, this field was required. If physician name missing, default "Referring, Physician MD." Also indicated that default=Physician Other.	N/A - Outpatient data not submitted
FL 84 – Remarks (used for DME billings by HHA)						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 1 – Provider name, address, and telephone number	VALID DATA ARE REQUIRED					
FL 2 – Untitled						
FL 3 – Patient control number	VALID DATA ARE REQUIRED					
FL 4 – Type of bill	No workaround used.	Used Medstat workaround: If valid type was unavailable, calculated bill type using provider location. None excluded.	Used Medstat workaround: If valid type was unavailable, calculated bill type using other claim information.	Used Medstat workaround: Calculated bill type using provider location, provider type, type of service.	No workarounds used.	
FL 5 – Federal tax number						
FL 6 – Statement covers period (from-through)	VALID DATA ARE REQUIRED					
FL 7 – Covered days FL 8 – Non-covered days FL 9 – Co-insurance days FL 10 – Lifetime reserve days FL 11 – Untitled						
FL 12 – Patient name	VALID DATA ARE REQUIRED					
FL 13 – Patient address						
FL 14 – Patient's birthdate						
FL 15 – Patient's sex						
FL 16 – Patient's marital status FL 17 – Admission date. FL 18 – Admission hour						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 19 – Type of admission (required on inpatient bills only)	Used Medstat workaround: Default value=9 (information not available) Most FIs permit this field to be blank on outpatient submissions.	Used Medstat workaround: default value=9. Also indicated that defaulted to "2".	Used Medstat workaround: Default value=9 (information not available)	Used Medstat workaround: Default value=9 (information not available)	No workarounds used.	
FL 20 – Source of admission	No workaround used; default value=1 or 4.	No workaround used.	Used Medstat workaround: Default value=3 (HMO Referral)	Used Medstat workaround: Default value=3 (HMO Referral)	No workaround used.	
FL 21 – Discharge hour						
FL 22 – Patient status	No workaround used.	No workaround used.	Used Medstat workaround: Patient status=1.	Used Medstat workaround: Patient status=1.	Valid data submitted.	
FL 23 – Medical record number	Used Medstat workaround: okay to default a different patient identifier.	Used Medstat workaround: defaulted PHN claim #.	Used Medstat workaround: Okay to default a different patient identifier.	Used St. Joseph's member number.	Valid data submitted.	
FL 24-30 – Condition codes	Condition codes pulled from claims data.	Condition codes pulled from claims data; calculated cond. codes using rev codes and bill types.	Condition codes were pulled from claims data.	Condition codes were pulled from claims data; used data from original claims.	Condition codes pulled from claims data.	
FL 31 – Untitled						
FL 32-35 – Occurrence codes and dates	Occurrence code date pulled from claims data.	Occurrence codes pulled from claims data; calculated using rev codes and bill types.	Occurrence codes pulled from claims data.	Condition codes were pulled from claims data; used data from original claims.	Occurrence codes pulled from claims data.	

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

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UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 36 – Occurrence span codes and dates	Span codes and dates pulled from claims data. Span codes and dates are primarily needed for SNF claim submission.	Span codes and dates pulled from claims data.	Span codes and dates pulled from claims data.	Span codes and dates stripped prior to sending.	Span codes and dates pulled from claims data.	
FL 37 – Internal control number/Document control number (ICN/DCN) FL 38 – Untitled						
FL 39-41 – Value codes and amounts	Value codes pulled from claims data.	Value codes pulled from claims data; calculated using type of bill and rev code info.	Value codes pulled from claims data; defaulted "05."	Value codes stripped prior to sending.	Value codes pulled from claims data.	

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UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 42 – Revenue code	No workaround used.	No workaround used.	No workarounds used.	Received crosswalks from Medstat using HCPCS and bill type. Stripped the following revenue codes prior to sending: 10, 99, 170, 160, 190, 199, 985, 636.	Valid data submitted.	
FL 43 – Revenue description						
FL 44 – HCPCS/Rates	No workarounds used.	Some claims were missing HCPCS and could not be submitted. 60% didn't go through the FI; were unable to send any corrected claims through TriSpan for anything other than TOB 11.	Not an outpatient field.	94% of claims missing HCPCS and submitted on flat file to HCFA. Remaining 6% sent to BCBS for processing.	No workarounds used.	
FL 45 – Service Date						
FL 46 – Service units						

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UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 47 – Total charges	VALID DATA ARE REQUIRED					
FL 48 – Non-covered charges	Used Medstat workaround: Totaled all charges for revenue codes 253, 256, 273, 96X, 97X, 98X, 99X.	No workaround used.	Not an outpatient field.	Used Medstat workaround: Totaled all charges for revenue codes 253, 256, 273, 96X, 97X, 98X, 99X.	No workarounds used.	
FL 49 - Untitled						
FL 50 A, B, C – Payer name	Used Medstat workaround: If Medicare was primary payer, defaulted "Medicare." If Medicare was secondary, primary payer name was used.	MSP claims not processed by FI.	Used Medstat workaround: If Medicare was primary payer, defaulted "Medicare." If Medicare was secondary, primary payer name was used.	BCBS GA (FI) processed MSP claims as though Medicare were primary.	No MSP claims were submitted.	
FL 50 A, B, C – Payer code	Used Medstat workaround: If Medicare was primary payer, default value = Z. If not primary, used A for Working Aged.	MSP claims not processed by FI.	Used Medstat workaround: If Medicare was primary payer, defaulted "Medicare." If Medicare was secondary, primary payer name was used.	BCBS GA (FI) processed MSP claims as though Medicare were primary.	Plan hard coded default of Z for MSP claims, but did not submit any MSP claims.	
FL 51 A, B, C – Provider number	VALID DATA ARE REQUIRED					
FL 52 – Release of information	Used Medstat workaround: default value=N (no release on file).	Used Medstat workaround: default value=N. Also indicated that defaulted to "Y".	No workaround used; defaulted to "Y".	Defaulted all claims to "Y" per BCBS.	Valid data submitted.	

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UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 53 – Assignment of benefits certification indicator						
FL 54 A, B, C – Prior payments.	Used Medstat workaround: Default value=zero fill.	No workaround used.	Used Medstat workaround: Default value=zero fill.	Used Medstat workaround: Default value=zero fill.	Valid data submitted.	
FL 55 – Estimated amount due FL 56 – Untitled FL 57 – Untitled						
FL 58 – Insured's name	Used Medstat workaround: If Medicare was not primary, used valid Insured's Name.	MSP claims not processed by FI.	Used Medstat workaround: If Medicare was not primary, used valid Insured's Name.	BCBS GA (FI) processed MSP claims as though Medicare were primary.	No MSP claims were submitted.	
FL 59 – Patient's relationship to insured	Used Medstat workaround: If Medicare was not primary, used value Patient Relationship to Insured.	MSP claims not processed by FI.	Used Medstat workaround: If Medicare was not primary, used value Patient Relationship to Insured.	BCBS GA (FI) processed MSP claims as though Medicare were primary.	No MSP claims were submitted.	
FL 60 – Cert/SSN/HIC/ ID number	VALID DATA ARE REQUIRED					
FL 61 – Group name	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group number of member's primary insurance group or plan.	MSP claims not processed by FI.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group number of member's primary insurance group or plan.	BCBS GA (FI) processed MSP claims as though Medicare were primary.	No MSP claims were submitted.	

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 62 – Insurance group number	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	MSP claims not processed by FI.	Used Medstat workaround: left blank if Medicare was primary; otherwise, used group name of member's primary insurance group or plan.	BCBS GA (FI) processed MSP claims as though Medicare were primary.	No MSP claims were submitted.	
FL 63 – Treatment authorization code						
FL 64 – Employment status code	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. Otherwise, valid data required.	MSP claims not processed by FI.	No workaround used; coded "9".	Default=9 (status unknown)	No MSP claims were submitted.	
FL 65 – Employer name (required if patient is employed)	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. If unavailable, default "Demonstration MSP."	MSP claims not processed by FI.	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. If unavailable, default "Demonstration MSP."	BCBS GA (FI) processed MSP claims as though Medicare were primary.	No MSP claims were submitted.	
FL 66 – Employer location	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. If unavailable, default plan address.	MSP claims not processed by FI.	Used Medstat workaround: left blank unless patient was working aged and/or Medicare was secondary. If unavailable, default plan address.	BCBS GA (FI) processed MSP claims as though Medicare were primary.	No MSP claims were submitted.	
FL 67 – Principal diagnosis code	VALID DATA ARE REQUIRED					
FL 68-75 Other diagnoses codes	N/A	Amisys holds 10.	Submitted 9 diagnoses.	Submitted a maximum of 3 diagnoses codes.	Submitted 9 diagnoses.	
FL 76 – Admitting diagnosis FL 77 – E-Code						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 78 – Untitled FL 79 – Procedure coding method						
FL 80 – Principal procedure code and date.	No workarounds used.	Amisys holds 10 proc codes.	No workarounds used.	Data was stripped from claim prior to submitting.	No workarounds used.	
FL 81 – Other procedure codes and dates.						
FL 82 – Attending/Referring physician ID	Used Medstat workaround: default admitting physician or PCP's UPIN. If unavailable, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's UPIN. If unavailable, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's UPIN. If unavailable, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's UPIN. If unavailable, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's UPIN. If unavailable, assign value=OTH000.	
FL 82 – Attending/Referring physician name	Used Medstat workaround: defaulted "Referring, Physician MD" if physician name was missing. Also indicated that default=Physician Attending	No workaround used.	Used Medstat workaround: defaulted "Referring, Physician MD" if physician name was missing.	Default="Attending physician"	Used Medstat workaround: Default="Referring, Physician MD"	

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

Appendix B: Review of Workarounds Applied to Institutional Outpatient Submissions

UB-92 Data Element - Outpatient	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516	Yellowstone - H2749
FL 83 – Other physician ID and name (required if an ambulatory HCPCS code is submitted)	Used Medstat workaround: default admitting physician or PCP's name and UPIN. If provider does not have a UPIN, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's name and UPIN. If provider does not have a UPIN, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's name and UPIN. If provider does not have a UPIN, assign value=OTH000.	Used Medstat workaround: default admitting physician or PCP's name and UPIN. If provider does not have a UPIN, assign value=OTH000.	Used Medstat workaround: Default admitting physician or PCP's UPIN. If provider does not have UPIN, assign value=OTH000.	
FL 83 – Other physician name (required if an ambulatory HCPCS code is submitted)	Used Medstat workaround: If a principal proc code was billed, this field was required. If physician name missing, default "Referring, Physician MD."	No workaround used.	Used Medstat workaround: If a principal proc code was billed, this field was required. If physician name missing, default "Referring, Physician MD."	Default = "Other Physician"	Used Medstat workaround: Default="Referring, Physician MD"	
FL 84 – Remarks (used for DME billings by HHA)						

When no workaround was used, either valid data were submitted or the claim was incomplete and could not be processed.

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 1 – Type of Health Insurance (receiver identification)		VALID DATA ARE REQUIRED				
FL 1 – Type of Health Insurance (receiver type code) FL 1 – Type of Health Insurance (claim editing indicator)						
FL 1a – Insured's ID number	#6 CAN #8 BIC	VALID DATA ARE REQUIRED				
FL 2 – Patient's Name (last name, first name, middle initial, patient generation)						
FL 3 – Patient's birthdate	#40 BENE_DOB	VALID DATA ARE REQUIRED				
FL 3 – Patient's sex	#38 SEX					
FL 4 – Insured's Name (insured last name, insured first name, insured middle initial, insured generation)	#42 SURNAME #43 FRSTINIT #44 MDL_INIT	MSP information submitted; MSP claims submitted as Medicare primary; claims denied and priced at $0.	All MSP submitted as primary.	All MSP submitted as primary.	MSP information submitted; MSP claims submitted as Medicare primary; claims denied and priced at $0. Field left blank.	All MSP submitted as primary.
FL 5 – Patient's address (patient address 1, patient address 2, patient city, patient state, patient zip, patient phone number)						
FL 6 – Patient's relationship to insured	#8 BIC	WHEN DA0-5.0 = C, THIS FIELD MUST = 01 (SELF). THUS, CODE VALUE= 01 FOR ALL MEDICARE DEMONSTRATION CLAIMS.				
FL 7 – Insured's address (insured address 1, insured address 2, insured city, insured state, insured zip, insured phone number)		REQUIRED ONLY IF THERE IS OTHER INSURANCE PRIMARY TO MEDICARE				
FL 8 – Patient status (patient marital status, patient student status, patient employment status) FL 9 – Other Insured's Name (payer organization identification) FL 9 – Other Insured's Name (payer name) FL 9 – Other Insured's Name (insured last name, insured first name, insured middle initial, insured generation)						

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 9 – Other Insured's Name (payer address 1, payer address 2, payer city, payer state, payer zip) FL 9a – Other Insured's Policy or Group Number (group number, group name, Medigap policy number) FL 9b – Other Insured's Date of Birth FL 9b – Other Insured's Sex FL 9c – Employer's Name or School Name						
FL 10 a-c – Is Patient's Condition Related to: a. Employment b. Auto Accident c. Other Accident		No workaround used; valid data available.	No workaround used; left blank.	Used Medstat workaround: If data unavailable, default N for not employment related and N for no accident.	Used Medstat workaround: If data unavailable, default N for not employment related and N for no accident.	Used Medstat workaround: If data unavailable, default N for not employment related and N for no accident.
FL 10 a-c – Is Patient's Condition Related to: (accident state)		Submitted accident state	Field left blank.	Field left blank.	Field left blank.	Field left blank.
FL 11 – Insured's Policy Group or FECA Number (claim editing indicator) FL 11 – Insured's Policy Group or FECA Number (source of pay)						
FL 11 – Insured's Policy Group or FECA Number (insurance type code)		No workaround used; valid data available. MSP claims submitted as Medicare primary; claims denied and priced at $0.	Used Medstat workaround: Medicare used as primary.	Used Medstat workaround: Valid data must be submitted. If Medicare was primary, value=MP. If secondary, assigned 12 - Working aged.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	MSP claims submitted as Medicare primary; claims denied and priced at $0.
FL 11 – Insured's Policy Group or FECA Number (payer organization identification)						

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 11 – Insured's Policy Group or FECA Number (payer name)		Used Medstat workaround: If Medicare was primary, left blank. Otherwise, valid data was submitted.	Used Medstat workaround: Medicare used as primary, left blank.	Left blank; used Medicare as primary.	Used Medstat workaround: Medicare used as primary, left blank.	Used Medstat workaround: Medicare used as primary, left blank.
FL 11 – Insured's Policy Group or FECA Number (group number, group name, payer address 1, payer address 2, payer city, payer state, payer zip)		MSP information available.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.
FL 11a – Insured's Date of Birth		MSP information available.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.
FL 11a – Insured's Sex		MSP information available.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.
FL 11b – Employer's Name or School Name		Used Medstat workaround: If Medicare was primary, left blank. Otherwise, valid data was submitted.	Used Medstat workaround: Medicare used as primary, left blank.	Used Medstat workaround: If Medicare was primary, left blank. Otherwise, valid data was submitted.	Left blank; used Medicare as primary.	Left blank; used Medicare as primary.
FL 11c – Insurance Plan Name or Program Name FL 11d – Is There Another Health Benefit Plan?						
FL 12 - Patient's or Authorized Person's Signature (assignment of benefits indicator)		No workaround used; default=N.	No workaround used; left blank.	Used Medstat workaround: Default value=Y.	No workaround used.	Used Medstat workaround: Default value=Y.
FL 12 - Patient's or Authorized Person's Signature (release of information indicator)		No workaround used; default=Y.	No workaround used; left blank.	Used Medstat workaround: Default value=N.	Used default=Y.	Used Medstat workaround: Default value=N.
FL 12 – Patient's or Authorized Person's Signature (release of information date)						

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 13 - Patient's or Authorized Person's Signature (patient signature source)		No workaround used; default=B.	Used Medstat workaround: Default value=C.	Used Medstat workaround: Default value=C.	No workaround used; default=B.	Used Medstat workaround: Default value=C.
FL 14 – Date of Current Illness, Injury, Pregnancy (accident/symptom date, initial treatment date)		No workaround used.	No workaround used; left blank.	Used Medstat workaround: Required for chiro claims. Default value for initial treatment date=first date of service on claim.	No workaround used.	Chiropractic claims were not submitted, workaround not used
FL 15 – If Patient Has Had Same or Similar Illness (same/similar symptom indicator) FL 16 – Dates Patient Unable to Work (disability from date, disability to date)						
FL 17 – Name of Referring Physician or Other Source (referring provider last name, referring provider first name, referring provider middle initial)		Used Medstat workaround: If provider name was unavailable, defaulted "Demonstration, Referring MD."	No workaround used; provided unless Place-of-Service was an 11 or 12.	No workaround used.	Used Medstat workaround: If provider name was unavailable, defaulted "Demonstration, Referring MD." Also indicated that default=Physician Referring.	Used Medstat workaround: If provider name was unavailable, defaulted "Demonstration, Referring MD." Also indicated that default=Physician Referring.
FL 17a – ID Number of Referring Physician (referring provider ID number)	#53 RFR_UPIN	Used Medstat workaround: Valid provider UPIN number was submitted. If provider not assigned UPIN, used OTH000.	No workaround used; provided unless Place-of-Service was an 11 or 12. OTH000 was not used.	Used Medstat workaround: If valid provider UPIN not available, used OTH000.	Used Medstat workaround: If valid provider UPIN not available, used OTH000.	Used Medstat workaround: If valid provider UPIN not available, used OTH000.
FL 18 – Hospital Dates Related to Current Services (admission date 1, discharge date 1)						

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 19 – Reserved for Local Use (date last seen)		No workaround used; defaulted to blank. Routine foot care not provided.	Routine foot care services not submitted; default not used.	Used Medstat workaround: Required only on routine foot care services that were submitted by an independent physical or occupational therapist or physician. For al other services, leave blank. If date missing, default first date of service on claim.	Routine foot services not submitted.	Routine foot care services not submitted; default not used.
FL 19 – Reserved for Local Use (supervising provider national provider identifier)		No workaround used; defaulted to blank. Routine foot care not submitted.	No workaround used.	Used Medstat workaround: Enter UPIN of the attending physician when an independent physical therapist or physician submits a claim for routine foot care. Default OTH000 if data are not available.	No workaround used.	No workaround used.
FL 19 – Reserved for Local Use (initial treatment date)		No workaround used.	No workaround used.	Used Medstat workaround: Required for chiro services with dates of service on or before 12/31/99. If data are missing, default=date of service. Not required for dates of service beginning 1/1/00.	Used Medstat workaround: Required for chiro services with dates of service on or before 12/31/99. If data are missing, default=date of service. Not required for dates of service beginning 1/1/00.	Chiropractic claims were not submitted, workaround not used

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 19 – Reserved for Local Use (date of last x-ray)		No workaround used.	No workaround used.	Used Medstat workaround: Required for chiro services. If data are missing, default=date of service.	Used Medstat workaround: Required for chiro services. If data are missing, default=date of service.	Chiropractic claims were not submitted, workaround not used
FL 19 – Reserved for Local Use (homebound indicator)		No workaround used; defaulted to blank.	N/A - This type of service is not provided.	N/A - This type of service is not provided.	Used Medstat workaround: Enter "Y" for Patient Is Homebound when an independent lab renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. Otherwise, leave blank.	No workaround used; defaulted to blank.
FL 19 – Reserved for Local Use (extra narrative data)		No workaround used; used only for date of cataract surgery.	Used Medstat workaround: left blank. <1% as errors.	None submitted. System will only pay if valid CPT; would have rejected NOC codes.	No workaround used; left blank. HAO always blank.	No workaround used; left blank. HAO always blank.
FL 20 – Outside Lab? Yes or No Charges Purchased Service (lab indicator)		No workaround used; defaulted to blank.	No workaround used; left blank.	Used Medstat workaround: default value=N except on lab claims where tests were performed by a lab other than the billing lab as identified by the Y1 or Y7 modifier. For these claims, default value=Y.	No workaround used; left blank. Field left blank, which would have caused some claims to reject.	No workaround used; left blank. Field left blank, which would have caused some claims to reject.
FL 20 – Outside Lab? Yes or No Charges Purchased Service (lab indicator)		Used Medstat workaround: default value=zero fill.	Used Medstat workaround: left blank. Default value=zero fill.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 20 – Outside Lab? Yes or No Charges Purchased Service (purchased service indicator)		Used Medstat workaround: default value=N.	No workaround used; left blank.	Used Medstat workaround: default value=N.	Used Medstat workaround: default value=N.	Used Medstat workaround: default value=N.
FL 20 – Outside Lab? Yes or No Charges Purchased Service (purchased service charge)						
FL 21 – Diagnosis/Condition (codes 1-4)	#46 PDGNS_CD #97 DGNS_CD	No workarounds used; up to 4 diagnoses codes submitted.	Fewer than 4 diagnoses codes could be submitted. Only one code sent.	Maximum of 3 diagnosis codes submitted.	No workarounds used; up to 4 diagnoses codes submitted.	No workarounds used; up to 4 diagnoses codes submitted.
FL 22 – Medicaid Resubmission FL 23 – Prior Authorization Number (prior auth no) FL 23 – Prior Authorization Number (investigational device exemption number) FL 23 – Prior Authorization Number (care plan oversight provider number)						
FL 23 – Prior Authorization Number (CLIA number)		Valid CLIA numbers submitted.	Lab services not submitted due to missing CLIA numbers.	Valid CLIA numbers submitted.	Defaulted CLIA number from 1 hospital.	Lab services submitted, but priced at zero due to missing CLIA numbers.
FL 23 – Prior Authorization Number (insurance location identifier) FL 24a – Dates of Service (service from date, service to date)						
FL 24b – Place of Service	#115 PLCSRVC	POS information pulled from claims.	POS information pulled from claims.	POS information pulled from claims.	POS information pulled from claims.	When information was missing, used default value=11 (provider's office).
FL 24c – Type of Service FL 24d – Procedures, Services, or Supplies (HCPCS procedure code, HCPCS modifier 1, HCPCS modifier 2)						

Appendix B: Review of Workarounds Applied to Professional Service DME Submissions

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 24e – Diagnosis code (diagnosis code pointer 1)	#147 LINEDGNS	No workaround used; valid data available.	Used Medstat workaround: default 1 to point all services to first diagnosis.	Used Medstat workaround: default 1 to point all services to first diagnosis.	No workaround used.	Used Medstat workaround: default 1 to point all services to first diagnosis.
FL 24f – Charges (line charges)	#137 LSBMTCHG	Line charge information submitted.	Line charge information submitted.	Line charge information submitted.	Line charge information submitted.	Line charge information submitted.
FL 24g – Days or Units (units of service)						
FL 24g – Days or Units (anesthesia/oxygen minutes)	#145 MTUS_CNT	No workarounds used.	Data submitted when proc code is between 00099 and 02000.	No workarounds used.	No workarounds used.	No workarounds used.
FL 24h – EPSTDT Family Plan (EPSDT indicator) FL 24I – EMG FL 24j – COB FL 24k – Reserved for Local Use (rendering provider ID) FL 25 – Federal Tax ID Number (provider tax ID, provider tax ID type, provider commercial number) FL 26 – Patient's Account Number (patient control number)						
FL 27 – Accept Assignment		Used Medstat workaround: default value=A (assigned).	Used Medstat workaround: default value=A (assigned).	Used Medstat workaround: default value=A (assigned).	Used Medstat workaround: default value=A (assigned).	Used Medstat workaround: default value=A (assigned).
FL 28 – Total Charge						
FL 29 – Amount Paid (patient amount paid)	#58 BENEPAID	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.
FL 30 – Balance Due						
FL 31 – Signature of Physician or Supplier (provider signature indicator)		Used Medstat workaround: default value=Y.	Used Medstat workaround: default value=Y.	Used Medstat workaround: default value=Y.	Used Medstat workaround: default value=Y.	Used Medstat workaround: default value=Y.
FL 31 – Signature of Physician or Supplier (provider signature date)						

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
FL 32 – Name and Address of Facility Where Services Were Rendered	#107 PROVZIP #106 PROVSTATE	Used Medstat workaround: Required when place of service was other than the patient's home or physician's office. If information was not available, defaulted "Facility not available" in field EA0 39.0 and leave the EA1 records blank.	Used Medstat workaround: Required when place of service was other than the patient's home or physician's office. If information was not available, defaulted "Facility not available" in field EA0 39.0 and leave the EA1 records blank.	Used Medstat workaround: Required when place of service was other than the patient's home or physician's office. If information was not available, defaulted "Facility not available" in field EA0 39.0 and leave the EA1 records blank.	Used Medstat workaround: Required when place of service was other than the patient's home or physician's office. If information was not available, defaulted "Facility not available" in field EA0 39.0 and leave the EA1 records blank. Default=*Independence Blue Cross*	Used Medstat workaround: Required when place of service was other than the patient's home or physician's office. If information was not available, defaulted "Facility not available" in field EA0 39.0 and leave the EA1 records blank.
FL 32 - Mammography cert number		Used Medstat workaround: For mammography services, enter the 6-digit mammography cert number. If not available, work with carrier to implement the default cert # 123456.	No workaround used; left blank.	Used Medstat workaround: For mammography services, enter the 6-digit mammography cert number. If not available, work with carrier to implement the default cert # 123456.	Used Medstat workaround: For mammography services, enter the 6-digit mammography cert number. If not available, work with carrier to implement the default cert # 123456.	No workaround used; left blank.
FL 33 – Physician's, Suppliers Billing Name, Address, Zip Code, and Phone Number (provider Medicare number)						
N/A – Ambulance Record (type of transport)		No workaround used.	Used Medstat workaround: default value = I (initial trip).	No workaround used.	Used Medstat workaround: default value = I (initial trip).	Workaround not used; claims may not have been submitted.
N/A – Ambulance Record (bed confined before)		No workaround used.	No workaround used; default value=N.	No workaround used.	Used Medstat workaround: default value = Y (patient was bed confined).	Workaround not used; claims may not have been submitted.
N/A – Ambulance Record (bed confined after)		No workaround used.	No workaround used; default value=N.	No workaround used.	Used Medstat workaround: default value = Y (patient was bed confined).	Workaround not used; claims may not have been submitted.

HCFA 1500 Data Element - Professional	NCHF Reference	Health Alliance - H1463	Health Partners - H3964	Health Plans of PA - H3966	IBC - H3963	Humana of Houston (MSCH) - H4572
N/A – Ambulance Record (moved by stretcher)		No workaround used.	No workaround used; default value=N.	No workaround used.	Used Medstat workaround: default value=Y (patient was moved by a stretcher).	Workaround not used; claims may not have been submitted.
N/A – Ambulance Record (unconscious/shock)		No workaround used.	No workaround used; default value=N.	No workaround used.	Used Medstat workaround: default value=Y (patient was unconscious or in shock).	Workaround not used; claims may not have been submitted.
N/A – Ambulance Record (emergency situation).		No workaround used.	No workaround used; default value=N.	No workaround used.	Used Medstat workaround: default value=Y (emergency situation).	Workaround not used; claims may not have been submitted.
N/A – Ambulance Record (original POS)		No workaround used.	No workaround used; default value=here.	No workaround used.	No workaround used; default=Choices Demo	Workaround not used; claims may not have been submitted.
N/A – Ambulance Record (destination)		No workaround used.	No workaround used; default value=there.	No workaround used.	No workaround used; default=Choices Demo	Workaround not used; claims may not have been submitted.

HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 1 – Type of Health Insurance (receiver identification)	VALID DATA ARE REQUIRED				
FL 1 – Type of Health Insurance (receiver type code) FL 1 – Type of Health Insurance (claim editing indicator)					
FL 1a – Insured's ID number	VALID DATA ARE REQUIRED				
FL 2 – Patient's Name (last name, first name, middle initial, patient generation)					
FL 3 – Patient's birthdate FL 3 – Patient's sex	VALID DATA ARE REQUIRED				
FL 4 – Insured's Name (insured last name, insured first name, insured middle initial, insured generation)	MSP information submitted.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	MSP claims not submitted.	MSP claims not submitted.
FL 5 – Patient's address (patient address 1, patient address 2, patient city, patient state, patient zip, patient phone number)					
FL 6 – Patient's relationship to insured	WHEN DA0-5.0 = C, THIS FIELD MUST = 01 (SELF). THUS, CODE VALUE= 01 FOR ALL MEDICARE DEMONSTRATION CLAIMS.				
FL 7 – Insured's address (insured address 1, insured address 2, insured city, insured state, insured zip, insured phone number)	REQUIRED ONLY IF THERE IS OTHER INSURANCE PRIMARY TO MEDICARE				
FL 8 – Patient status (patient marital status, patient student status, patient employment status) FL 9 – Other Insured's Name (payer organization identification) FL 9 – Other Insured's Name (payer name) FL 9 – Other Insured's Name (insured last name, insured first name, insured middle initial, insured generation)					

Appendix B: Review of Workarounds Applied to Professional Service DME Submissions

HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 9 – Other Insured's Name (payer address 1, payer address 2, payer city, payer state, payer zip) FL 9a – Other Insured's Policy or Group Number (group number, group name, Medigap policy number) FL 9b – Other Insured's Date of Birth FL 9b – Other Insured's Sex FL 9c – Employer's Name or School Name					
FL 10 a-c – Is Patient's Condition Related to: a. Employment b. Auto Accident c. Other Accident	Used Medstat workaround: If data unavailable, default N for not employment related and N for no accident.	No workaround used.	Used Medstat workaround: If data unavailable, default N for not employment related and N for no accident.	Used Medstat workaround: If data unavailable, default N for not employment related and N for no accident.	Used Medstat workaround: If data unavailable, default N for not employment related and N for no accident.
FL 10 a-c – Is Patient's Condition Related to: (accident state)	Field left blank.	Field left blank.	Field left blank.	Field left blank.	Field left blank.
FL 11 – Insured's Policy Group or FECA Number (claim editing indicator) FL 11 – Insured's Policy Group or FECA Number (source of pay)					
FL 11 – Insured's Policy Group or FECA Number (insurance type code)	Used Medstat workaround: Valid data must be submitted. If Medicare was primary, value=MP. If secondary, assigned 12 - Working aged.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	Used Medstat workaround: Valid data must be submitted. If Medicare was primary, value=MP. If secondary, assigned 12 - Working aged.	MSP claims not submitted.	No workarounds used.
FL 11 – Insured's Policy Group or FECA Number (payer organization identification)					

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 11 – Insured's Policy Group or FECA Number (payer name)	Used Medstat workaround: Medicare used as primary, left blank.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	Used Medstat workaround: If Medicare was primary, left blank. Otherwise, valid data was submitted.	MSP claims not submitted.	MSP claims not submitted.
FL 11 – Insured's Policy Group or FECA Number (group number, group name, payer address 1, payer address 2, payer city, payer state, payer zip)	MSP information available.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	Always spaces.	MSP claims not submitted.	MSP claims not submitted.
FL 11a – Insured's Date of Birth	MSP information available.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	Valid date.	MSP claims not submitted.	MSP claims not submitted.
FL 11a – Insured's Sex	MSP information available.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	Data provided.	MSP claims not submitted.	MSP claims not submitted.
FL 11b – Employer's Name or School Name	Used Medstat workaround: If Medicare was primary, left blank. Otherwise, valid data was submitted.	MSP claims submitted as Medicare primary; claims denied and priced at $0.	MSP claims not submitted.	MSP claims not submitted.	MSP claims not submitted.
FL 11c – Insurance Plan Name or Program Name FL 11d – Is There Another Health Benefit Plan?					
FL 12 - Patient's or Authorized Person's Signature (assignment of benefits indicator)	No workaround used.	Used Medstat workaround: Default value=Y.	No workaround used; data from claim, no test.	Used Medstat workaround: Default value=Y.	Used Medstat workaround: Default value=Y.
FL 12 - Patient's or Authorized Person's Signature (release of information indicator)	No workaround used.	Used Medstat workaround: Default value=N. Also indicated that defaulted to "M".	No workaround used; always coded "Y".	Used Medstat workaround: Default value=N.	Defaulted value=Y.
FL 12 – Patient's or Authorized Person's Signature (release of information date)					

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

Appendix B: Review of Workarounds Applied to Professional Service DME Submissions

HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 13 - Patient's or Authorized Person's Signature (patient signature source)	No workaround used.	Used Medstat workaround: default=C. Also indicated that defaulted to "B".	Used Medstat workaround: Default value=C.	Used Medstat workaround: default=C. Also indicated that defaulted to "B".	Default value=B.
FL 14 – Date of Current Illness, Injury, Pregnancy (accident/symptom date, initial treatment date)	Used Medstat workaround: Required for chiro claims. Default value for initial treatment date=first date of service on claim.	Used Medstat workaround: Required for chiro claims. Default value for initial treatment date=first date of service on claim.	Always field spaces. No GCO - records sent.	No workaround used.	No workaround used.
FL 15 – If Patient Has Had Same or Similar Illness (same/similar symptom indicator) FL 16 – Dates Patient Unable to Work (disability from date, disability to date)					
FL 17 – Name of Referring Physician or Other Source (referring provider last name, referring provider first name, referring provider middle initial)	No workaround used.	No workaround used.	Used Medstat workaround: If provider name was unavailable, defaulted "Demonstration, Referring MD."	Defaulted to "Referring Physicians".	Used Medstat workaround: If provider name was unavailable, defaulted "Demonstration, Referring MD."
FL 17a – ID Number of Referring Physician (referring provider ID number)	Used Medstat workaround: If valid provider UPIN not available, used OTH000.	Used Medstat workaround: If valid provider UPIN not available, used OTH000.	Used Medstat workaround: If valid provider UPIN not available, used OTH000.	Left "Blank". May have caused some claims to reject.	Used Medstat workaround: If valid provider UPIN not available, used OTH000.
FL 18 – Hospital Dates Related to Current Services (admission date 1, discharge date 1)					

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 19 – Reserved for Local Use (date last seen)	Used Medstat workaround: Required only on routine foot care services that were submitted by an independent physical or occupational therapist or physician. For al other services, leave blank. If date missing, default first date of service on claim.	No workaround used; data not seen.	Always spaces.	No workaround used.	No workaround used.
FL 19 – Reserved for Local Use (supervising provider national provider identifier)	Used Medstat workaround: Enter UPIN of the attending physician when an independent physical therapist or physician submits a claim for routine foot care. Default OTH000 if data are not available.	Used Medstat workaround: Enter UPIN of the attending physician when an independent physical therapist or physician submits a claim for routine foot care. Default OTH000 if data are not available.	Always spaces.	No EA1 record types submitted.	Used Medstat workaround: Enter UPIN of the attending physician when an independent physical therapist or physician submits a claim for routine foot care. Default OTH000 if data are not available.
FL 19 – Reserved for Local Use (initial treatment date)	Used Medstat workaround: Required for chiro services with dates of service on or before 12/31/99. If data are missing, default=date of service. Not required for dates of service beginning 1/1/00.	No workaround used; *not sure 35.*	No GCO records submitted.	No GCO records submitted. No chiro service provided?	No workaround used.

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HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 19 – Reserved for Local Use (date of last x-ray)	Used Medstat workaround: Required for chiro services. If data are missing, default=date of service.	No workaround used.	No GCO records submitted.	No GCO records submitted.	No workaround used.
FL 19 – Reserved for Local Use (homebound indicator)	Used Medstat workaround: Enter "Y" for Patient Is Homebound when an independent lab renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. Otherwise, leave blank.	No workaround used; denied.	Always spaces.	Used Medstat workaround; however, indicated that defaulted to "Blank".	No workaround used.
FL 19 – Reserved for Local Use (extra narrative data)	Used Medstat workaround: Required when NOC proc code was billed. Otherwise, left blank.	No workaround used;	Used Medstat workaround: Required when NOC proc code was billed. Otherwise, left blank.	No HA0 record types submitted.	No workaround used; denied. Not corrected. 7-8% error rate.
FL 20 – Outside Lab? Yes or No Charges Purchased Service (lab indicator)	No workaround used.	No workaround used.	Always spaces.	Used Medstat workaround: default value=N except on lab claims where tests were performed by a lab other than the billing lab as identified by the Y1 or Y7 modifier. For these claims, default value=Y.	No workaround used.
FL 20 – Outside Lab? Yes or No Charges Purchased Service (lab indicator)	Used Medstat workaround: default value=zero fill.	No workaround used.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 20 – Outside Lab? Yes or No Charges Purchased Service (purchased service indicator)	Used Medstat workaround: default value=N.	No workaround used.	Used Medstat workaround: default value=N.	Used Medstat workaround: default value=N.	No workaround used.
FL 20 – Outside Lab? Yes or No Charges Purchased Service (purchased service charge)					
FL 21 – Diagnosis/Condition (codes 1-4)	No workarounds used; up to 4 diagnoses codes submitted.	No workarounds used; up to 4 diagnoses codes submitted.	No workarounds used; up to 4 diagnoses codes submitted.	Maximum of 3 diagnosis codes submitted.	Maximum of 3 diagnosis codes submitted.
FL 22 – Medicaid Resubmission FL 23 – Prior Authorization Number (prior auth no) FL 23 – Prior Authorization Number (investigational device exemption number) FL 23 – Prior Authorization Number (care plan oversight provider number)					
FL 23 – Prior Authorization Number (CLIA number)	Lab services submitted, but priced at zero due to missing CLIA numbers.	Valid CLIA numbers submitted.	Valid CLIA number from 1 hospital used where CLIA numbers were missing.	Valid CLIA number from 1 hospital used where CLIA numbers were missing.	Valid CLIA numbers submitted.
FL 23 – Prior Authorization Number (insurance location identifier) FL 24a – Dates of Service (service from date, service to date)					
FL 24b – Place of Service	POS information pulled from claims.	POS information pulled from claims.	POS information pulled from claims.	POS information pulled from claims.	POS information pulled from claims.
FL 24c – Type of Service FL 24d – Procedures, Services, or Supplies (HCPCS procedure code, HCPCS modifier 1, HCPCS modifier 2)					

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

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HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 24e – Diagnosis code (diagnosis code pointer 1)	No workaround used.	Used Medstat workaround: default 1 to point all services to first diagnosis.	Used Medstat workaround: default 1 to point all services to first diagnosis.	Used Medstat workaround: default 1 to point all services to first diagnosis. Defaulted on all claims.	Used Medstat workaround: default 1 to point all services to first diagnosis.
FL 24f – Charges (line charges)	Line charge information submitted.	Line charge information available.	Line charge information available.	Line charge information submitted.	Line charge information submitted.
FL 24g – Days or Units (units of service)					
FL 24g – Days or Units (anesthesia/oxygen minutes)	No workarounds used.	Used 1 rather than 0001.	Anesthesia and/or oxygen charges stripped from claim when proc 0700.	No workarounds used.	No workarounds used.
FL 24h – EPSTDT Family Plan (EPSDT indicator) FL 24I – EMG FL 24j – COB FL 24k – Reserved for Local Use (rendering provider ID) FL 25 – Federal Tax ID Number (provider tax ID, provider tax ID type, provider commercial number) FL 26 – Patient's Account Number (patient control number)					
FL 27 – Accept Assignment	No workaround used.	Used Medstat workaround: default value=A (assigned).	Used Medstat workaround: default value=A (assigned).	Used Medstat workaround: default value=A (assigned).	Used Medstat workaround: default value=A (assigned).
FL 28 – Total Charge					
FL 29 – Amount Paid (patient amount paid)	Used Medstat workaround: default value=zero fill.	No workaround used; left blank.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.	Used Medstat workaround: default value=zero fill.
FL 30 – Balance Due					
FL 31 – Signature of Physician or Supplier (provider signature indicator)	Used Medstat workaround: default value=Y.	No workaround used.	Used Medstat workaround: default value=Y.	Used Medstat workaround: default value=Y.	Used Medstat workaround: default value=Y.
FL 31 – Signature of Physician or Supplier (provider signature date)					

When no workarounds were used, plan either submitted valid data or submitted a claim with missing data. Claims with missing data were either rejected or denied.

HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
FL 32 – Name and Address of Facility Where Services Were Rendered	Used Medstat workaround: Required when place of service was other than the patient's home or physician's office. If information was not available, defaulted "Facility not available" in field EA0 39.0 and leave the EA1 records blank.	Used Medstat workaround: Required when place of service was other than the patient's home or physician's office. If information was not available, defaulted "Facility name not available" in field EA0 39.0 and leave the EA1 records blank.	Always spaces.	Used Medstat workaround: Required when place of service was other than the patient's home or physician's office. If information was not available, defaulted "Facility name not available" in field EA0 39.0 and leave the EA1 records blank.	No workaround used; valid info submitted?
FL 32 - Mammography cert number	Used Medstat workaround: For mammography services, enter the 6-digit mammography cert number. If not available, work with carrier to implement the default cert # 123456.	No workaround used; mammography claims accepted.	Used Medstat workaround: For mammography services, enter the 6-digit mammography cert number. If not available, work with carrier to implement the default cert # 123456.	No workaround used; mammography claims rejected.	Used Medstat workaround: For mammography services, enter the 6-digit mammography cert number. If not available, work with carrier to implement the default cert # 123456.
FL 33 – Physician's, Suppliers Billing Name, Address, Zip Code, and Phone Number (provider Medicare number)					
N/A – Ambulance Record (type of transport)	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	No workaround used.
N/A – Ambulance Record (bed confined before)	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	No workaround used.
N/A – Ambulance Record (bed confined after)	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	No workaround used.

HCFA 1500 Data Element - Professional	Mount Carmel - H3668	PHN - H1961	Secure Choice - H1163	St. Joseph's - H1169	UCSD - H0516
N/A – Ambulance Record (moved by stretcher)	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	No workaround used.
N/A – Ambulance Record (unconscious/shock)	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	No workaround used.
N/A – Ambulance Record (emergency situation).	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	No workaround used.
N/A – Ambulance Record (original POS)	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	No workaround used.
N/A – Ambulance Record (destination)	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	Ambulance services not submitted.	No workaround used.

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